2025

St. Vincent IPA
Provider Manual

Provider Relations Department: (562) 860-8771

ST. VINCENT IPA

The Patient's Choice for Health Care

www.stvincentipa.com

Welcome Letter

Dear St. Vincent IPA Provider,

With so many Medical Groups and Independent Practice Associations (IPAs) to choose from, we thank you for selecting St. Vincent IPA Medical Group and would like to welcome you to the network. St. Vincent IPA has provided quality and care to tens of thousands of patients for over 20 years and is excited to have you as a participating provider.

Our objective is to manage the use of healthcare resources responsibly without impending our provider's ability to deliver appropriate, quality healthcare and we are looking forward to a long and mutually beneficial relationship. Should you have any questions regarding the information enclosed or need further assistance, please do not hesitate to contact me at (562) 860-8771, ext. 108.

To ensure you are set up to start receiving/referring patients as soon as possible, please make sure you are set up with a login to our online referral/claim portal, Aerial Care: https://aerial.carecoordination.medecision.com/login.html

A Username and Password can be requested by contacting Aerial Care directly at 1-800-864-8160. This number can also be utilized for any technical assistance. You can also request a login by contacting our Provider Relations Department at (562) 860-8771, ext. 112. We accept electronic claim submission through Aerial Care or Office Ally (866) 575-4120.

Our St. Vincent IPA's Payor ID is PDT01.

For more information on St. Vincent IPA including information about contracted health plans, urgent care locations, hospitals, labs, and etc., please visit our website: **stvincentipa.com.** Should you have any questions regarding the information enclosed or need further assistance, please do not hesitate to contact me at (562) 860-8771, ext. 108.

Michael L Gella
IPA Manager/Administrator | Physicians DataTrust

Affirmative Statement

PHYSICIANS DATATRUST

INTEROFFICE MEMORANDUM

TO: PCP, SCP, Clinical Services and Administrative Staff

FROM: Lisa Serratore, Chief Executive Officer

CC: Evelyn Jimenez, IPA Manager, CVPG
Clarissa Lomeli, IPA Manager, GPMG
Kailah Burton, IPA Manager, GTC IPA
Mary Beltran, IPA Administrator, Noble AMA IPA; Exec. Dir. IPA Administration
Michael Gella, IPA Manager, St. Vincent IPA

DATE: January 8, 2025

RE: Affirmative and Impartiality Statements

AFFIRMATIVE STATEMENT

As a utilization management organization, Physicians DataTrust on behalf of Citrus Valley Physicians Group, Golden Physicians Medical Group, Greater Tri Cities IPA, Noble AMA IPA, and St. Vincent IPA, ensures that all decisions are made based on the available medical information at the time of the request. Should a member ask to see the criteria utilized to make a medical decision; the statement below is attached to that guideline, as required by the National Committee for Quality Assurance (NCQA):

Decisions regarding requests for medical care are based on the medical necessity of the request, the appropriateness of care and service and existence of coverage. There is no monetary reward for non-approval of services. Compensation for individuals who provide utilization review services does not contain incentives, direct or indirect, for these individuals to make inappropriate review decisions.

Utilization review criteria, based on reasonable medical evidence and acceptable medical standards of practice (i.e. MCG and/or applicable health plan guidelines) are used to make decisions pertaining to the utilization of services. Review Criteria are used in conjunction with the application of professional medical judgment, which considers the needs of the individual patient and characteristics of the local delivery system.

IMPARTIALITY STATEMENT

All participating practitioners are ensured independence and impartiality in making referral decisions which will not influence hiring, compensation, termination, promotion or any other similar matters.

These statements are also on our websites: www.cvpg.org, www.gpmedicalgroup.com, www.gtcipa.com, , www.nobleamaipa.com, and www.stvincentipa.com, along with other valuable information for our contracted providers and our members, and can be printed, if needed. Our business hours are Monday through Friday, 9:00a.m. to 5:00p.m. and Administrative staff can be reached at (760) 941-7309 or (800) 458-2307 during business hours. Should you have a question for the Utilization Management Department after hours, you may call (760) 941-7309 or (800) 458-2307 and leave a message for someone to call you back the next business day.

161 Thunder Dr., Ste. 212 Vista, CA 92083 • Office (760) 941-7309

Distribution of this Manual

This Manual is delivered by St. Vincent IPA, Marketing Department to the Physicians' office when a Physician joins the IPA. An electronic version is also available on our website, www.stvincentipa.com.

Updates to this Manual

Updates to this manual will be available to all contracted providers on St. Vincent IPA's website. Additional communications related to health plan information, customer service, operations, or community information will be faxed out.

PCP Provider Listings

Our PCP Directory is available on-line and is updated on a monthly and ad-hoc basis. The website is available to both physicians and members with Internet access.

To access the Physician listings:

- Connect to the Internet and go to http://www.stvincentipa.com
- Our home page will appear. Click "Find A Provider" at the bottom of the page.

If your office does not have Internet access, please contact Provider Relations department at **(562) 860-8771 Ext. 112** to receive a listing.

Provider Directory Changes

The Provider Directory data is what is current in our systems. If you have a change of address, phone number, fax number, etc. please notify our Provider Relations Department of any changes, so that our directories and listings reflect your current information. Prompt notification is required to ensure checks, important announcements, reports, and communications are delivered to you in a timely manner.

Services

Hospitalist/Case Management

It is critical that only the St. Vincent IPA contracted Hospitalist admit and follow your patients requiring hospitalization.

Dr. Imad El Asmar
Office: (213) 487-6867
Pager: (310) 232-2332

- Hollywood Presbyterian Medical Center

If you have a St. Vincent IPA patient that is requiring Hospital Emergency or In-Patient Services, please make sure to contact St. Vincent IPA's Case Management Department at:

During business hours: **(562) 860 - 8771**
After hours: **(562) 257 -7893**

St. Vincent IPA Important Lines

ADMINISTRATION	Phone	Fax	Email
Dr. Imad El Asmar *Medical Director*	(213) 487-6867	(310) 232-2332 (pager)	
Michael Gella *IPA Manager / Administrator*	(562) 860-8771, ext 117	(562) 207-6547	mgella@pdtrust.com
CLAIMS	**Phone**	**Fax**	**Mailing Address**
	(562) 860-8771, ext 2000	(760) 631-7614	Primary Care Physicians – Encounter Data St. Vincent IPA PO Box 4999 Oceanside, CA 92052 Fee-for-Service (FFS) Claims PO Box 5089 Oceanside, CA 92052
For Appeals, please fax to (760) 631-7614			
Please mail all Claims and Encounter Data on a CMS-1500 form			
CLINICAL SERVICES	**Phone**	**Fax**	**Email**
Authorizations	(562) 860-8771, ext 2001		
Referrals	(562) 860-8771, ext 2001	(562) 924-1453	
Utilization Management	(562) 860-8771, ext 2001	(562) 924-1453	
For issues not being resolved for the Authorization department, please call x169 or x177			
CREDENTIALING	**Phone**	**Fax**	**Email**
Maria Gonzales *Credentialing Coordinator*	(760) 941-7309, ext 105	(562) 270-3528	mgonzales@pdtrust.com
NETWORK DEVELOPMENT	**Phone**	**Fax**	**Email**
Valerie Chaidez *Network Development Rep*	(562) 860-8771, ext 165	(562) 207-6577	vchaidez@pdtrust.com
Brandace Baldwin Network Development Rep	(562) 860-8771, ext 188	(213) 262-2057	bbrandace@pdtrust.com
PROVIDER RELATIONS	**Phone**	**Fax**	**Email**
Alejandra Hernandez *Provider Relations Specialist*	(562) 860-8771, ext 112	(562) 207-6558	ahernandez@pdtrust.com
RISK ADJUSTMENT	**Phone**	**Fax**	**Email**
Caroline Begins *Risk Adjustment Manager*	(562) 941-7309, ext 227	(760) 630-3676	cbegins@pdtrust.com

St. Vincent IPA

The Patient's Choice for Health Care
For Hospital Needs

To ensure the highest level of care for inpatient needs, St. Vincent IPA is contracted with several of the region's top hospitals. Please review the list below for our network of contracted hospitals.

Our hospital network handles inpatient services. **If you have an emergency, call 911 or go to the closest emergency room**. Once you are stable, you will be transferred to an in-network facility for the remainder of your care.

Hollywood Presbyterian Medical Center
1300 North Vermont Avenue
Los Angeles, CA 90027
Phone: (213) 413-3000

Good Samaritan Hospital
1225 Wilshire Boulevard
Los Angeles, CA 90017
Phone: (213) 977-2121

California Hospital Medical Center
1401 South Grand Avenue
Los Angeles, CA 90015
Phone: (213) 748-2411

St. Vincent IPA

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For Radiology Facilities

There are times when your provider will want you to see a radiologist. In these instances, services will be performed at one of the facilities list on this page. Your primary care doctor will give you an order for the radiological exam and direct you to the appropriate facility. Many questions about your radiological procedure can be answered by contacting the imaging department at the facility you will be visiting.

For providers: If you need to refer your patients to another facility, please contact our Provider Relations Department at (562) 860-8771 Ext. 112.

Renaissance Imaging Center, Downtown
500 South Virgil Ave
Suite 102
Los Angeles, CA 90020
Phone: (323) 375-3950

SHIN IMAGING CENTER
266 S Harvard Blvd #18
Los Angeles, CA 90004
Phone: (213) 387-3002
Fax: (213) 387-3057

St. Vincent is also partnered with UMI and Radnet chains. To find an imaging center near you, please visit http://www.umih.com/locations/ and https://www.radnet.com/imaging-centers/find-an-imaging-center

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For Urgent Medical Needs That Are Not Life-Threatening

URGENT CARE	ADDRESS	PHONE	HOURS
Dusk to Dawn Urgent Care	1045 W Redondo Beach Blvd., Ste. 138 Gardena, CA 90247	(310) 323-2273	Mon -Fri 9am-9pm Sat-Sun 9am-2pm
Dusk to Dawn Urgent Care	323 North Prairie Ave. Inglewood, CA 90301	(310) 673-2273	Mon-Fri 9am-9pm Sat-Sun 9am-2pm
Dusk to Dawn Urgent Care	3680 E Imperial Hwy., Ste. 410 Lynwood, CA 90262	(310) 639-2220	Mon-Fri 9am-9pm Sat-Sun 9am-2pm
Dusk to Dawn Urgent Care	15745 Paramount Blvd. Paramount, CA 90723	(562) 808-2273	M-F 9am-12am Sat-Sun 9am-6pm
Glen Oaks Urgent Care	1100 W Glenoaks Blvd. Glendale, CA 91202	(818) 242-3333	Mon-Fri 9am-8pm Sat-Sun 9am-5pm
The Urgent Care at Vermont	1234 North Vermont Ave. Los Angeles, CA 90029	(323) 660-0831	Mon-Fri 9am-7pm Sat 9am-3pm
Vernon Urgent Care	231 W Vernon Ave., Ste. 112 Los Angeles, CA 90037	(323) 234-1468	Mon-Fri 11am-9 pm Sat-Sun 9am-6pm
Holy Cross Urgent Care	4864 Santa Monica Blvd. Los Angeles, CA 90029	(323) 660-7770	Mon,Wed,Fri 3-9pm Tue,Thur,Sat,Sun 9am-9pm
CINA Urgent Care	3756 Santa Rosalia Dr. Los Angeles, CA 90008	(310) 742-5961	Mon-Th 8am-6pm Sat 8am-2pm
LA Downtown Medical Clinic LLC (formerly Silver Lake Urgent Care)	1711 West Temple St., Second Floor Los Angeles, CA 90026	(213) 989-6160	Always Open 24/7
Reliant UC- Santa Fe Springs	11460 Telegraph Rd. Santa Fe Springs, CA 90670	(310) 491-7060	Mon-Fri 8:30am-8pm Sat-Sun 10am-5pm
Reliant UC- Huntington Park	5900 Pacific Blvd. Huntington Park , CA 90255	(310) 740-9867	Mon-Fri 8am - 9pm Sat-Sun 10am-5pm
Reliant UC- Blvd Los Angeles	5901 W Century Blvd., Los Angeles, CA 90045	(310) 910-9752	Always Open 24/7
Reliant UC- Street Los Angeles	814 S Francisco St. Los Angeles, CA 90017	(310) 597-4408	Mon-Fri 7:00am - 1:30am Sat-Sun 7am-11pm
Reliant UC- Blvd Montebello	2300 W Beverly Blvd. Montebello, CA 90640	(626) 587-3424	Mon-Fri 8am-9pm Sat-Sun 10am-5pm

Commonly treated illnesses at an Urgent Care

- Sore throat, fever or ear aches
- Minor injuries, burns, and lacerations
- Skin infections and rashes
- Sinus problems/other upper respiratory infection
- Minor fractures or broken bones
- Backaches/Sports Injuries
- Frequent urination/Burning sensation
- Persistent vomiting
- Abdominal pain or cramping
- Allergic reactions
- Insect or animal bites

Benefits of accessing an Urgent Care vs. ER

- Avoid long waiting time in the emergency room
- Urgent cares provide quality care
- Faster care, the average visit lasts under an hour
- Avoid higher co-pays for an emergency room visit
- Urgent Cares offer extended hours

ST. VINCENT IPA

stvincentipa.com (562) 860-8771

Labs

St. Vincent IPA has partnered with Quest Diagnostics to provide routine laboratory services to our members. Quest Diagnostics has many convenient locations throughout Los Angeles County to ensure that you do not have to go far for lab services.

To find a lab near you, you can also use the Quest Diagnostics Find-A-Lab tool by going to this link: https://secure.questdiagnostics.com/hcp/psc/jsp/SearchLocation.do

Customer Care Center/ Appointments: (866) 697-8378

Contracted Healthplans

Medicare Advantange Plans

- Aetna
- Alignment
- Anthem Blue Cross
- Blue Shield
- Molina/Brand New Day
- Molina/Central Healht Plan
- Health Net
- LA Care
- Scan Health Plan
- United Health Care
- Wellcare
- Humana

Commercial Plans

- Aetna
- Anthem Blue Cross
- Blue Shield
- Cigna
- Health Net
- LA Care Covered California
- United Healthcare

Medi-cal

- Anthem Blue Cross
- Blue Shield Promise
- Health Net
- LA Care

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PROVIDER RESPONSIBLILTIES

Provider Responsibilities

Primary Care Physician Responsibilities

1. **Basic PCP Responsibilities**
   - Provide outpatient clinic care during normal business hours (Monday-Friday from 9a.m to 5p.m.)
   - Twenty-four hour On-call coverage
   - Provide cross coverage with an IPA contracted physician
   - Recommend and coordinate the care of consulting specialists
   - Telephone consultation to members contracted to the primary care physician's service

2. **Routine Office visits**
   - Well baby care (Family Practice/Pediatrics), including developmental assessment and patient/parent education
   - Complete physicals as outlined in Health Plan guidelines
   - T.B. Skin Test/Mantou
   - Preventive medical care including health risk identification, education, reduction, and periodic screening

3. **State Mandated Referrals**
   - Well Woman Exam
   - Mammography
   - Family Planning*
   - Vision Care*

4. **Injections**
   - Antibiotics, vitamins, hormones, flu vaccine, etc
   - Allergy treatment(in conjunction with treatment plan from Allergist if appropriate); not including sensitivity testing or antigen preparation
   - Authorized injectables (Betaseron, neupogen, etc.)

5. **Opthalmology**
   - Basic vision test
   - Removal of foreign body, external eye
   - Removal of foreign body, corneal, w/o slit lamp

6. **ENT**
    - Routine audiometry
    - Drainage external ear, abscess or hematoma; simple
    - Removal foreign body from external auditory canal
    - Removal impacted cerumen, one or both ears
    - Control of nasal hemorrhage, anterior simple

7. **Digestive System**
    - Proctosigmoidoscopy; diagnostic; rigid or flexible up to 25 cm**
    - Anoscopy; diagnostic
    - Colon cancer screening; age >50 yearly hemoccult testing with patient off
    - ASA/NSAID; Refer for flexible sigmoidoscopy every 3-5 years

8. **Musculoskeletal System**
    - Arthrocentesis aspiration or injection; small joint bursa, or ganglion cyst
    - Injection of tendon, ligament, trigger points, or ganglion cysts**
    - Care of routine and uncomplicated rheumatic and orthopedic conditions

9. **Localized burns**
    - Initial treatment first degree burns

10. **Surgical Procedures**
    - Simple repair of scalp, trunk and /or extremities lacerations <2.5 cm
    - Simple repait of lacerations 2.6-7.5 cm**
    - Incision and drainage of abscesses
    - Incision and drainage of pilonidal cyst
    - Removal of foreign body
    - Drainage of hematoma
    - Puncture aspiration
    - Debridement
    - Excision of benign lesions
    - Incision of thromboses hemorrhoid, external**
    - Destruction of lesion(s) anus(condyloma, papilloma, molluscum contagiosum)
    - Suture removal

11. **Reproductive System**
    - Destruction of lesions penis, simple, with chemicals
    - Destruction of lesions of vulva
    - Diaphragm fitting**
    - Treatment of uncomplicated venereal diseases
    - Other gynecologic procedures

12.Dermatologic Procedures

- Acne care
- Excision of benign lesions
- Excision of malignant lesions
- Biopsy of skin, subcutaneous tissue and /or mucous membrane
- Destruction of pre-malignant lesions
- Wart removal
    i. Cryotherapy
    ii. Electrosurgical
- Avulsion of nail plate**
    i. Partial
    ii. Complete
- Matricectomy**
- Evacuation of subungual hematoma**

13.Other Office Procedures

- Venipuncture
- EKG
- Diagnosis of alcohol/chemical dependency
- Recognition of psychological problems, including routine outpatient management of anxiety and depression
- Treatment and follow-up of uncomplicated hypertension
- Management and follow-up of uncomplicated, controlled diabetes mellitus

14.Advanced procedures

- Flexible Sigmoidoscopy**

* Check benefits prior to referral

** If PCP feels that the procedure is complex, or has required excessive time to treat, a referral to self may be submitted to Utilization Management for authorization and reimbursement. An explanation or report may be necessary.

National Provider Identifier

The National Provider Identifier (NPI) is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

To obtain, update or find more information, please visit npiregistry.cms.hhs.gov

As outlined in the Federal Regulation, The Health Insurance Portability and Accountability Act of 1996 (HIPAA), covered providers must also share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes.

More detailed information is available on https://www.cms.gov/Regulations-and-Guidance/Administrative-Simplification/NationalProvIdentStand/

Access Standards

We have adopted access guidelines using both the California Managed Health Care Quality Coalition as well as the National Committee on Quality Assurance (NCQA). A copy of the access standards is located on the next page.

Compliance to these Guidelines will be monitored and coordinated with other activities throughout the organization. Ways this is monitored may include member surveys and complaints. The IPA will conduct Member and Provider Surveys on a yearly basis focusing on appointment scheduling, waiting times and after hours care.

A summary sheet illustrating the access standards is provided on the following page.

AFTER HOURS ACCESS REQUIREMENTS

After Hours Access includes the following measures:

1. **Access** - After Hours recording or answering service must state emergency instructions to address medical emergencies (e.g. "If this is an emergency, please dial 911 or go to your nearest emergency room.")

2. **Access** - After Hours recording or answering service must state a way of contacting the provider (e.g. connect directly to the provider, leave a message and the provider will call back, page provider, etc.)

3. **Timeliness** - Recording or live person must state that provider will call back within 30 minutes

   Note: Providers must be compliant in all three of the above measures to be considered compliant with L.A. Care's After Hours standards

4. **Combined Access & Timeliness** – Compliance for both Access and Timeliness standards.

SAMPLE HOURS SCRIPT

In order to comply with all DMHC the suggested script examples will help to ensure that you meet SVIPA standards. Please modify your answering service script immediately, if not already implemented.

Example 1
"You have reached the office of (give Dr. name) our office is closed. If this is a life threatening medical emergency, please hang up and dial 911 or go to your nearest emergency room otherwise, please leave your name, number including your area code **& (give Dr. name) will automatically be paged and will return your call within 30 minutes."**

Example 2
"You have reached the office of (give Dr. name) our office is closed. If this is a life threatening medical emergency, please hang up and dial 911 or go to your nearest emergency room otherwise, please leave your name, number including your area code **& (give Dr. name) will automatically be paged and will return your call within 30 minutes."**

Example 3:
"You have reached the office of (give Dr. name) our office is closed. If this is a life threatening medical emergency, please hang up and dial 911 or go to your nearest emergency room otherwise, **(give Dr. name) may be reached at (give alternate phone number)."**

As an active provider for St. Vincent IPA, please be advised that you must adhere to all health plan requirements and most importantly honor your provider contract.

Please be aware that our St. Vincent IPA provider relations department will randomly select providers every month to check their after hours message.

Access to Care Standards: Commercial and Medicare Advantage Members

Primary Care Physician (PCP)	Standard
Emergency (Serious condition requiring immediate intervention)	Immediately (office, UCC, ER)
Urgent (Condition that could lead to a potentially harmful outcome if not treated)	*Within 48 hours (office, UCC)
Non-Urgent (routine) *(visit for symptomatic but not requiring immediate diagnosis and/or treatment)	*Within 10 business days
Adult or Pediatric Health Assessment / Physical *(Physical: periodic health evaluation with no acute medical problem) *(Preventive: for prevention and early detection of disease, illness, condition)	Within 30 calendar days, unless more prompt exam is warranted
****IHA (18 months and older)**	Within 120 days of enrollment
****IHA (under 18 months)**	Within 60 days of enrollment
Waiting Time in physician office	Less than 30 minutes
After-hours Access	Answering Service or service w/ option to page Provider
• Enrollee with life threatening medical problem must have access to health care twenty-four (24) hours per day and 7 days per week. • After hours answering system or voice mail should instruct members that if they feel they have a serious acute medical condition, to seek immediate care by calling 911 or going to the nearest Emergency Room. • **Member must be assured that a Health Care Professional (Dr., Advice Nurse, PA, NP) will communicate with them within 30 minutes.	
****Telephone Triage and Screening (urgent and routine)** • Telephone triage is available 24 hours a day and 7 days a week	**Within 30 minutes

Specialty Care Provider (SCP)	Standard
Urgent referral (includes Behavioral Health)	Within 96 hours
*Non-Urgent / routine** (includes Behavioral Health)	*Within 15 business days from time of PCP request

Behavioral Health Provider (based on Plan contracts)

Appointment	Standard
Urgent	Within 96 hours
Routine	*Within 15 business days
**Non-physician BH	** 10 business days

**Ancillary Services	Standard
Urgent (for diagnosis and treatment)	Within 96 hours
Routine (for diagnosis and treatment)	*Within 15 business days from time of PCP request

*Revised Standard 2011 ** New Standard 2011 Compliance = 80%

Access to Care Standards: Dual Eligible (Medi-Medi) and Special Needs Plan (SNP) Members

Service	Standard
Appointment making systems	A written or computerized appointment making system, which includes following up on missed appointments
Appointments for routine primary care services for a member who is symptomatic but does not require immediate diagnosis and/or treatment	30 calendar days maximum
Appointments for routine prenatal care	• Within two weeks from request during the 1st and 2nd trimester • Within three working days from request during 3rd trimester
Appointments for routine preventative care	Physical exam/preventative services – four (4) weeks maximum for appointment
Appointments for urgent care	Within 24 hours
Routine specialty referral appointment	Within 10 working days
Availability of interpreter Service	24 hours/7 days a week
Availability of primary care physician – time requirements	24 hours/7 days a week
Routine specialty referral appointment	Within 10 working days
Availability of interpreter Service	24 hours/7 days a week
Availability of primary care physician – time requirements	24 hours/7 days a week
Preventative Exams A periodic health evaluation for a member with no acute medical problem, including: • Initial Health • Assessments and Behavioral Risk Assessments	Children under the age of 18 months – within 60 calendar days of enrollment or within the AAP periodicity timelines for ages two and younger, whichever is less 18 months of age and older – within 120 calendar days of enrollment EPSDT/CHDP or preventative health

	examination within four weeks from request.
Preventative Exams A periodic health evaluation for a member with no acute medical problem, including: • Initial Health • Assessments and Behavioral Risk Assessments	Children under the age of 18 months – within 60 calendar days of enrollment or within the AAP periodicity timelines for ages two and younger, whichever is less 18 months of age and older – within 120 calendar days of enrollment EPSDT/CHDP or preventative health examination within four weeks from request
AAP periodic screenings	As prescribed by AAP Periodicity guidelines
Emergency appointment: Services for a potentially life threatening condition requiring immediate medical intervention to avoid disability or serious detriment to health	Immediate, 24 hours a day/7 days a week
Non-emergent telephone appointment responsiveness	45 minutes
Office waiting time: The time a member with a scheduled medical appointment is waiting to see a doctor once in the office	5 – 45 minutes
Telephone waiting time: The maximum length of time for office staff to answer the phone	30 seconds
Call Return Time (After Hours): The maximum length for PCP or on-call provider to return a call	30 minutes
Services for members with disabilities	Compliance with all provisions of the Americans with Disabilities Act: • At least one designated handicapped parking space • A handicapped bathroom or alternative access which is equipped with handrails in the bathroom • A wheelchair access ramp • A handicapped water fountain or alternative provisions • An elevator

Availability of ancillary services	Available within a reasonable distance from the primary care physician
Availability of hospitals	Travel time and distance standards of 15 miles travel distance or 30 minutes travel time from their residence or workplace
Availability of primary care physician distance requirements (PCP Geo Access Reports)	Travel time and distance standards of 10 miles travel distance or 30 minutes travel time from their residence or workplace
Availability of specialty care	Travel time and distance standards of 15 miles travel distance
Member requested primary care physician changes	Members can request a PCP change monthly. Health Plans will process the member requested PCP change
Routine specialty referral authorization	Within 10 working days

ST. VINCENT IPA

CREDENTIALING

The Patient's Choice for Health Care

Credentialing

General Information

Credentialing is the process of obtaining, verifying and assessing the qualifications of a healthcare practitioner to provide patient care services in or for a healthcare entity.

To ensure consistency of credentialing and recredentialing, a routine process should be followed. This assures accuracy of approach and process as well as minimize the variation of references provided. Use of the same process for each new application or re-applicant also reduces the opportunity of charges of discrimination (from the applicant) if there is a negative outcome.

St. Vincent IPA will regularly obtain and review documentation on practitioner sanctions, complainants, adverse events and quality issues and implement appropriate interventions when poor quality, safety issues or limitations on licensure or exclusion from participation are identified. Among the types of media used, these sources have been identified as pertinent information used in the ongoing assessment of Practitioners.

- Reports publicized by licensing boards
- OIG Exclusions and Reinstatement Report/Database
- Medi-Cal Suspended and Ineligible Provider List maintained on the Medi-Cal website
- Medicare Opt Out Report
- SAM (System for Award Management) formerly known as Excluded Parties List System (EPLS)
- Member complaints, filed with the Health Plan or St. Vincent IPA
- Quality of Care issues, identified by the Health Plan or St. Vincent IPA
- Adverse Events, identified by Health Plan or St. Vincent IPA

Credentialing

Red Flags

The indicators below will not necessarily result in denial, only that an explanation is required. A practitioner should be afforded the opportunity to submit additional information in support of the application.

The Credentialing department will consider all factors when reviewing practitioner credentials.

- Missing dates or gaps in training or professional practice
- Discrepancies between information provided on application and verified information
- Suspension, reprimand, revocation, or challenge to licensure
- Excessive professional liability history, either in the number of claims filed or judgements awarded

Credentialing

Updating Expireables

Time sensitive documents such as primary state license, DEA certificate, malpractice insurance coverage will be kept current at all times.

- California state license must be updated no more than five days of expiration
- DEA will be verified with the next available update from the provider
- Insurance coverage will be verified with the next available update from the provider

Credentialing

Recredentialing Process

One hundred and twenty (120) days prior to the end of the three-year appointment period, you will receive the Practitioner's pre-populated re-credentialing application. The practitioner is required to review the information; make any necessary updates or corrections; then sign and date where it is indicated.

Please return the completed re-credentialing application and any supporting documents as requested. The reapplication will be processed, information verified, reviewed by the Credentialing department and updated in our database.

QUESTIONS?

Maria Gonzalez
Credentialing Supervisor| Physicians DataTrust
PHYSICIANS DATATRUST
Greater Tri Cities IPA |Noble AMA IPA |St. Vincent IPA
Golden Physicians Medical Group | Citrus Valley Physicians Group
(760)941-7309 Ext 105
(562)270-3528
www.pdtrust.com

Physician Credentialing Sample Letter

Dear Provider:

As you may be aware, our contracted health plans require that providers be re-credentialed every three (3) years. Our records indicate that you are due for re-credentialing with **St. Vincent IPA**. It is imperative we receive your re-credentialing application without delay in order to meet health plan deadlines. Please note that failure to comply with the re-credentialing process may result in the closure of your office to new members or termination from **St. Vincent IPA**.

Enclosed is your reappointment application for **«Specialty_name»,** which needs to be completed and returned in the enclosed self-addressed envelope **IMMEDIATELY**.

Directions for completing application:

- Complete Re-Application with all current information
- Complete and sign Addendums A, B, C, & W-9 taxpayer for**m (Please be sure to sign all addendum's whether they pertain to you or not).**
- Please include copies of your current DEA, & Professional Liability Insurance.

In accordance with St. Vincent IPA standards, Providers have the right to review information submitted in support of their credentialing and/or recredentialing application. This includes information received from any outside primary source verification entities.

We kindly request your prompt attention to this very important request. If you should have any questions regarding your application, please contact me directly at **(562) 860-8771, ext 124**.

Sincerely,

REFERRALS

Referrals

Frequently Asked Questions

1. **What is the best way to submit a referral?**
   The best way to submit a referral is through Aerial Care.

2. **What is needed to submit a clean referral?**
   There are four things that are needed to submit a clean referral:

   1. Request of the contracted provider
   2. Recent office notes and pertinent diagnostic results
   3. Use the correct CPT code
   4. Use of the correct priority

3. **How do I determine if the request needs to be expedited?**
   Routine requests are for just that, routine, non-emergent evaluations, follow ups or testing. Urgent priority is for symptoms that warrant the service to be done sooner rather than later. STAT is typically used for blood transfusions or head CTs after a fall

4. **What is the TAT regulation?**
   Routine for seniors is 14 calendar days, 5 business days for commercial/Medi-Cal, urgent is 72 hours and STAT is 24 hours.

5. **How long is the reasonable expectation to have routine referrals determined**
   Within 3-4 business days if submitted cleanly.

6. **How do I know when a determination has been made?**
   You can check in Aerial care. Decisions are available in real time.

7. **Why do I need to attach notes?**
   This is strictly monitored and audited by the health plans on a regular basis.

8. **What is the best way to communicate with someone in clinical services?**
   You can message them in Aerial Care, be advised if you are requesting a J code or a service that requires review, you may need to submit another referral request. Please note that anything changed in our system takes 24 hours for the provider office to see in Aerial Care.

Aerial Care
New User Reference Guide

The Aerial Care system allows our providers to submit Referral Requests and Claims as well as the ability to check on their status and verify a patient's eligibility. Below are steps to help you log-in and get started using Aerial Care.

If you do not have an Aerial Care Log-in for St. Vincent IPA, please call us at (888) 255-5053.

Aerial Care Log-in Steps

1. Go to the St. Vincent IPA website at www.stvincentipa.com

2. Click on **Aerial Care & Referrals** under the **Provider Information tab** on the Provider's side of the website. You will the click the Aerial Care icon that will direct you to the Aerial Care web portal.

3. Type in your **Username** and **Password**.
   New Users: Enter your Temporary Password. You will then be asked to change the password to one of your choice. Then enter your New Password to log-in.\

4. To submit a Referral Request or check status click on one of the following:
   

5. To submit/Upload a Claim or Claim Batches click one the following:
   

6. To download your e-list click on the **Eligibility** Tab at the top of the page
   

7. Then Click the **Download to Excel** button
   

- If you cannot find a member listed in Aerial Care, Click on the Member Inquiry Form and complete all the required information. It will be submitted directly to our Eligibility Department. The member will be loaded in Aerial Care once eligibility is confirmed.

- If you are not able to scan and attach notes and/or additional information to your online Referral Request, please fax those to (562) 924-1453. Please note in the online Referral Notes that additional information will be submitted via fax.

- If you have any technical issues with Aerial Care, or forget your username and/or password, you may contact Aerial Care at (800) 864-8160.

- Online training is available 24/7. You can watch live videos, print out "quick reference" documents and instructions anytime just login and click on the Training Tab at the top of the page.

If you have any questions or would like additional training on Aerial Care, please contact the Provider Relations Department at (562) 860-8771 Ext. 107 or Ex 112.

Aerial Care

On-line Referral Submission

Referral Submission

St. Vincent IPA (SVIPA) provides a Web Portal for on-line referral submissions. Internet access must be available in order to view and submit referrals. Simply follow the steps below to easily set up your own on-line referral process for your SVIPA members.

Contact Aerial Care at **1-800-864-8160, Option#1** to obtain a user name and password.

Web Portal Address

Once a username and password have been set up; go to www.aerial.carecoordination.medecision.com

Click on the Log- in button on the right upper hand.

Login instructions

Look for the St. Vincent IPA logo and click on the Physician option

- Enter your login user ID and password.
- First time log-in will promote a change of password.

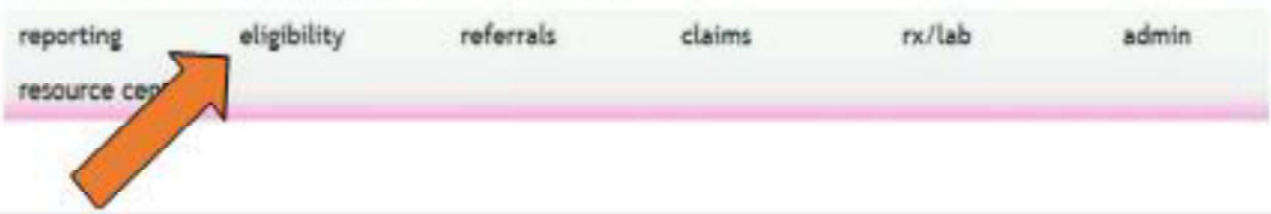
Please note; you will be promoted to change your password every 30 days. You may reuse the same password every time.

Aerial Care Dashboard

Once in the portal, a main screen will appear named the "dash board." You will see recent referral comments and or clinical alerts.

Entering a referral

Click on the eligibility tab on the dash board



Adding a New Member

Once the member's eligibility has been verified with the health plan, please fax an eligibility attestation form to **(562) 207-6511** in order to have the new member added to our database. Please allow 24 hours for the member to appear on the on- line portal.

If you are unable to find your member after confirmation with the health plan, please fill out the Member Add Request Form.

You can submit to prsvipa@pdtrust.com or fax to (562) 924-1603.

Request for authorization extension
Eligibility Attestation – STC-IPA

Patient Name _____

Auth # _____

Expiration date on auth _____

Request to extend authorization until _____

Reason for request _____

I understand that it is the responsibility of our office to check eligibility of the patient within two days of the service being rendered and to keep documentation of eligibility verification in the patient's file.

_____ Date _____

_____ @ _____

Member Add Request Form

Complete all fields below and fax this form to *(760) 477-2951*

Please note that this form is for non-urgent Member Adds only. If you have a patient who requires a medically urgent referral, please fax the referral directly to the UM Department for expedited processing. Requests will be processed within 3 business days. You may submit Member Add requests electronically, by logging into Aerial Care and selecting "Create a New Member Inquiry" under the Eligibility Tab.

** **All fields must be completed for your request to be processed.**

Provider Name:			
Contact Name		Contact Phone#	
Contact Fax#			
Purpose for this Request:	☐ New Member ☐ Health Plan Change ☐ Update Member information (Member information is received from the Health Plan. Member must notify their Plan of any necessary updates.) ☐ Date of Birth ☐ Address ☐ Sex ☐ Other :		
Health Plan		Health Plan Member ID	
Member First Name		Member Last Name	
Member Date of Birth		Effective Date	
Comments			
To Be Completed by IPA:			
Response: ☐ Member has been added or updated; Changes will be reflected in next month's capitation report. ☐ Member is not eligible with IPA Name / PCP ☐ Form Incomplete / Information Submitted can not be verified with Health Plan ☐ Other:			

- **Urgent**
  48 hour turn around time
  (medical necessity must be indicated)

- **STAT**
  24 hour turn around
  (medical necessity must be indicated)

- **Retro**
  Not to exceed more than 30 days from DOS

***Please note; urgent or STAT referrals entered due to administrative purposes will be downgraded from urgent/ STAT to routine. Please enter referrals in a timely manner.

*** Do not schedule appointments or procedures prior to obtaining authorization to ensure the member does not need to be rescheduled.

Indicate Services

- **Indicate Place of Service:**

Office, outpatient includes (surgery center,
outpatient hospital procedures less than 24hrs.) Inpatient, or Home (are a few of the most common)

Indicate Services & Quantity: CPT CODES

Please use appropriate modifiers as indicated.

CPT Codes

St. Vincent IPA uses a *claims editing software* which contains commercially available coding rules and guidelines to monitor internal claims processing and identify unclean claims which may require reduced payment for improper or erroneous coding.

When referrals with multiple CPT codes are received, it is processed through *claims editing software*, for appropriate claims processing. *Claims editing software* unbundles compounded codes and identifies compounded procedures. During the UM process, bundled CPT codes are removed from the referral. Please note; if CPT codes are taken off the request, look under the comment section and rational will be provided. If further clarification is needed please present provided information to your billing department.

Global Periods

Post-op global periods

- **10**- Day Post- Operative Period, (minor procedures)
- **90**- Day Post- Operative Period, (major procedures)
- Follow up referrals may often be canceled due to members being under a post op period. During this post op period all office physician based visits are covered under a global procedural authorization and no authorization is warranted.
- Modifier **-25-** may be used to bill a separately identifiable evaluation and management (E/M) service by the same physician. If, the member presents with separate issue/ condition non related to the surgical procedure, the physician may evaluate, treat and bill the new condition with a 25 modifier.

Your member's diagnosis

- Enter the most accurate **ICD-10Code (s)** provided by the physician

Every referral requires supporting documentation. It may either be faxed to (562) 207-6511, attached and or copied or pasted into the clinical symptoms/findings section of the request below (preferred).

Documentation is needed for review and to establish medical necessity.

Submit your members referral

- Lastly, once the referral is all set, click submit referral button.

- If, information is missing, please review the referral and make sure all required fields are entered.

- Once submitted, it will ask for the name of person entering the referral, please type in a point of contact.

- The last screen allows you to enter another referral for the same member, attach a document or edit the referral.

DIRECT REFERRAL FORMS

REFERRAL FORM

St. Vincent IPA Medical Corporation
Fax: (562) 924-1453 Phone: (562) 860-8771 Ext.2001

APPLICABLE COPAY	AUTHORIZATION NUMBER

Date of Referral Request: _____/_____/_____

☐ **Routine** ☐ **Urgent** ☐ **Emergent**

☐ **Specialist Request** ☐ **PCP Request**

Verbal notification to member of approval is required within 2 business days.
Member notified - Date: **Time:** **Notified by:**

Patient Name: (First, MI, Last) _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/_____ Phone: _____ Patient ID#: _____

Health Plan: _____

PCP Name: _____ Tel #: _____ Fax #: _____

Date of Last PCP Visit: _____ Date of Last Specialist Visit: _____

MD Office Staff Contact Name: _____ **Specialty Requested:**

MD Asking for Request: _____ _____

Tel #: _____ Fax #: _____

SIGNATURE OF REQUESTING PROVIDER:
(MANDATORY – WILL NOT BE PROCESSED WITHOUT SIGNATURE) _____

∴ Diagnosis: _____ ICD-10: _____

ICD-10: _____

Procedure/Service Requested: _____ CPT CODE: _____

CPT CODE: _____

CPT CODE:

Place of Service: ☐ **Office** ☐ **Out-Patient** ☐ **In-Patient** **Name Facility:** _____

Reason for REFERRAL: _____

Attachment

Notes: _____
Lab: _____
EKG/EEG: _____
X-Ray _____
Other: _____

FOR USE BY ST. VINCENT IPA MEDICAL CORPORATION UM STAFF ONLY

☐ Authorize Date: _____ ☐ Pending Date: _____ ☐ Modified Date: _____

☐ Denied Date: _____ ☐ Not a covered benefit ☐ T P L ☐ Alternate Treatment Plan

Comments/Remarks: _____

UM Signature: _____ **Date:** _____

Date PCP Notified: _____ **Please notify member today of referral status.**

Certification does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions. This certification is good for ninety (90) days from approval date. Referring providers may request a copy of the UM criteria or discuss their request with the IPA physician reviewer at any time. Your UM Case Management or Referral Coordinator will facilitate your request.

∴ This section must be reviewed by physician prior to submission.

LA AREA DIRECT REFERRAL REQUISITION FORM

Date of Referral Request: _____/_____/_____

St. Vincent IPA c/o Physicians DataTrust, Inc.
P. O. Box 5089 Oceanside, CA 92052
Phone: (562) 860-8771/Fax: (562) 924-1453

Patient Name (First, MI, Last): _____

Address: _____ **City:** _____ **State:** _____ Zip: _____

Date of Birth: _____/_____/_____ **Phone:** ( ) _____ **Patient ID #:** _____

Health Plan: _____

Referring Physician: _____ Referring Physician Signature: _____

Referring Physician Phone: ( ) _____ Referring Physician Fax: ( ) _____

Diagnosis ***(must be listed)*** _____

NOTICE TO PATIENT: Your primary care physician has approved your visit to the provider/specialist listed below. Please call the phone number listed below to make an appointment for mammography screening, CT Sinus Survey, and routine OB/GYN services on this form. Walk-in appointments are accepted for all other X-Ray services on this form.

PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT.

NOTICE TO SPECIALIST: The above-listed patient has been referred to you for the procedure indicated.

X-RAY (PLEASE INDICATION AND SERVICE TYPE)

☐ **Renaissance Imaging Center Virgil**
500 S. Virgil Ave.
Suite 102
Los Angeles, CA 90020
Tel: 323-375-3940
Fax: 323-375-3945

☐ **SHIN MRI LLC**
266 S Harvard Blvd.
Suite 180
Los Angeles, CA 90004
Tel. 213-387-3002
Fax 213-387-3057

☐ **PIH HEALTH**
1245 Wilshire Blvd.
Suite 205
North Tower
Los Angeles, CA 90017
Tel: 213-977-2140
Fax: 213-202-7003
(No Mammography At this time)

☐ **UMI of Los Angeles**
1127 Wilshire Blvd.
#100
Los Angeles, CA 90017
Tel: 213-223-5000

☐ **Radnet Beverly Towers Women's Center**
465 Roxbury Dr.
Suite 101
Beverly Hills, CA 90210
Tel: 310-385-7747

X-RAY TYPE: *** CPT CODES NOT LISTED REQUIRE SUBMISSION OF ROUTINE REFERRAL FORM***

HEAD & NECK
- ☐ 70250 - Skull < 4V
- ☐ 70486-CT Sinus Survey

CHEST
- ☐ 71045 - 1V
- ☐ 71046 - 2V
- ☐ 71100 - Ribs Uni 2V
- ☐ 71120 - Sternum Min 2V

SPINE & PELVIS
- ☐ 72040-Spine Cervical 2 or 3V
- ☐ 72070-Spine Thoracic 2V
- ☐ 72100-Spine Lumbosacral 2-3V
- ☐ 72170-Pelvis 1V
- ☐ 72220-Sacrum & coccyx min 2V

MAMMOGRAPHY
- ☐ 77067 Mammography Screening, Digital (age 40+)

UPPER EXTREMITIES
- ☐ 73030 - Shoulder min 2V
- ☐ 73070 - Elbow 2V
- ☐ 73090 - Forearm 2V
- ☐ 73100 - Wrist 2V
- ☐ 73120 - Hand 2V
- ☐ 73140 - Fingers min 2V

ABDOMEN
- ☐ 74018-anteroposterior 1V

LOWER EXTREMITIES
- ☐ 73502 - Hip unilateral min 2V
- ☐ 73521 - Hip bilateral min 2V
- ☐ 73552 - Femur 2V
- ☐ 73560 - Knee 1 or 2V
- ☐ 73590 - Tibia & Fibula 2V
- ☐ 73600 - Ankle 2V
- ☐ 73620 - Foot 2V
- ☐ 73650 - Calcaneus min 2V
- ☐ 73660 - Toes min 2V

LA AREA DIRECT REFERRAL REQUISITION FORM

ROUTINE OB/GYN WOMEN'S HEALTH (PLEASE COMPLETE PROVIDER INFORMATION &/ SERVICE TYPE

OB/GYN Provider Name: _____

Address: _____

City, Zip Code: _____

Phone _____

REVIEW CURRENT ROSTER
(MUST BE A CONTRACTED ST. VINCENT IPA PROVIDER)

Service Type:

☐ 99203 – OB/GYN Consult ☐ 99395 - Well Women Exam (Annual) – Age 18-39 ☐ 99397 - Well Women Exam (Annual) – Age >65

☐ 99213 - OB/GYN Follow-up ☐ 99396 - Well Women Exam (Annual) – Age 40-64

GLENDALE AREA DIRECT REFERRAL REQUISITION FORM

Date of Referral Request: _____/_____/_____

St. Vincent IPA c/o Physicians DataTrust, Inc.
P. O. Box 5089 Oceanside, CA 92052
Phone: (562) 860-8771/Fax: (562) 924-1453

Patient Name (First, MI, Last): _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Phone: ( ) _____ Patient ID #: _____

Health Plan: _____

Referring Physician: _____ Referring Physician Signature: _____

Referring Physician Phone: ( ) _____ Referring Physician Fax: ( ) _____

Diagnosis *(must be listed)*: _____

NOTICE TO PATIENT: Your primary care physician has approved your visit to the provider/specialist listed below. Please call the phone number listed below to make an appointment for mammography screening, CT Sinus Survey, and routine OB/GYN services on this form. Walk-in appointments are accepted for all other X-Ray services on this form.

PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT.

NOTICE TO SPECIALIST: The above-listed patient has been referred to you for the procedure indicated.

X-RAY (PLEASE : LOCATION AND SERVICE TYPE)

☐ **Radnet**
Imaging Specialists of Glendale
700 N. Central Ave, #100
Glendale, CA 91203
Tel: 818-480-7234
Fax 818-342-0303

☐ **Radnet**
Imaging Specialist of Burbank
1821 Olive St.
Burbank, CA 91506
Tel. 818-841-8880
Fax. 841-841-8884

☐ **Radnet - Mamo**
Imaging Specialist of Glendale
222 W Eulalia St.
Glendale, CA 99204
Tel. 818-502-2323
Fax. 818-342-0303

☐ **Renaissance Imaging Center Virgil**
500 S. Virgil Ave.
Suite 102
Los Angeles, CA 90020
Tel: 323-375-3940
Fax: 323-375-3945

X-RAY TYPE: ***CPT CODES NOT LISTED REQUIRE SUBMISSION OF ROUTINE REFERRAL FORM***

HEAD & NECK
☐ 70250 - Skull <4V
☐ 70486-CT Sinus Survey

CHEST
☐ 71045 - 1V
☐ 71046 - 2V
☐ 71100 - Ribs Uni 2V
☐ 71120 - Sternum Min 2V

SPINE & PELVIS
☐ 72040-Spine Cervical 2 or 3V
☐ 72070-Spine Thoracic 2V
☐ 72100-Spine Lumbosacral 2-3V
☐ 72170-Pelvis 1V
☐ 72220-Sacrum & coccyx min 2V

MAMMOGRAPHY
☐ 77067 Mammography Screening, Digital (age 40+)

UPPER EXTREMITIES
☐ 73030 - Shoulder min 2V
☐ 73070 - Elbow 2V
☐ 73090 - Forearm 2V
☐ 73100 - Wrist 2V
☐ 73120 - Hand 2V
☐ 73140 - Fingers min 2V

ABDOMEN
☐ 74018-anteroposterior 1V

LOWER EXTREMITIES
☐ 73502 - Hip unilateral min 2V
☐ 73521 - Hip bilateral min 2V
☐ 73552– Femur 2V
☐ 73560 - Knee 1 or 2V
☐ 73590 - Tibia & Fibula 2V
☐ 73600 - Ankle 2V
☐ 73620 - Foot 2V
☐ 73650 - Calcaneus min 2V
☐ 73660 - Toes min 2V

GLENDALE AREA DIRECT REFERRAL REQUISITION FORM

ROUTINE OB/GYN WOMEN'S HEALTH: PLEASE COMPLETE PROVIDER INFORMATION & / SERVICE TYPE

OB/GYN Provider Name: _____

Address: _____

City, Zip Code: _____

Phone _____

☚ REVIEW CURRENT ROSTER *(MUST BE A CONTRACTED ST. VINCENT IPA PROVIDER)*

Service Type:

☐ 99203 – OB/GYN Consult ☐ 99395 - Well Women Exam (Annual) – Age 18-39 ☐ 99397 - Well Women Exam (Annual) – Age >65

☐ 99213 - OB/GYN Follow-up ☐ 99396 - Well Women Exam (Annual) – Age 40-64

HP AREA DIRECT REFERRAL REQUISITION FORM

Date of Referral Request: _____/_____/_____

St. Vincent IPA c/o Physicians DataTrust, Inc.
P. O. Box 5089 Oceanside, CA 92052
Phone: (562) 860-8771/Fax: (562) 924-1453

Patient Name (First, MI, Last): _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Phone: (_____) _____ Patient ID #: _____

Health Plan: _____

Referring Physician: _____ Referring Physician Signature: _____

Referring Physician Phone: (_____) _____ Referring Physician Fax: (_____) _____

Diagnosis ***(must be listed)***: _____

NOTICE TO PATIENT: Your primary care physician has approved your visit to the provider/specialist listed below. Please call the phone number listed below to make an appointment for mammography screening, CT Sinus Survey, and routine OB/GYN services on this form. Walk-in appointments are accepted for all other X-Ray services on this form.

PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT.

NOTICE TO SPECIALIST: The above-listed patient has been referred to you for the procedure indicated.

X-RAY (PLEASE √ LOCATION AND SERVICE TYPE)

☐ **Renaissance Imaging Center Virgil**
500 S. Virgil Ave.
Suite 102
Los Angeles, CA 90020
Tel: 323-375-3940
Fax: 323-375-3945

☐ **UMI of Maywood**
4316 E. Slauson Ave.
Maywood, CA 90270
Tel: 323-374-6200

☐ **Huntington Park Advanced Imaging**
2680 Saturn Ave., Ste. 100
Huntington Park, CA 90255
Tel: 323-584-3333

X-RAY TYPE: ***CPT CODES NOT LISTED REQUIRE SUBMISSION OF ROUTINE REFERRAL FORM***

HEAD & NECK
☐ 70250 - Skull <4V
☐ 70486-CT Sinus Survey

CHEST
☐ 71045 –1V
☐ 71046 –2V
☐ 71100 - Ribs Uni 2V
☐ 71120 - Sternum Min 2V

SPINE & PELVIS
☐ 72040-Spine Cervical 2 or 3V
☐ 72070-Spine Thoracic 2V
☐ 72100-Spine Lumbosacral 2-3V
☐ 72170 -Pelvis 1V
☐ 72220-Sacrum & coccyx min 2V

MAMMOGRAPHY
☐ 77067 Mammography Screening, Digital (age 40+)

UPPER EXTREMITIES
☐ 73030 - Shoulder min 2V
☐ 73070 - Elbow 2V
☐ 73090 - Forearm 2V
☐ 73100 - Wrist 2V
☐ 73120 - Hand 2V
☐ 73140 - Fingers min 2V

ABDOMEN
☐ 74018-anteroposterior 1V

LOWER EXTREMITIES
☐ 73502 - Hip unilateral min 2V
☐ 73521 - Hip bilateral min 2V
☐ 73552 – Femur 2V
☐ 73560 - Knee 1 or 2V
☐ 73590 - Tibia & Fibula 2V
☐ 73600 - Ankle 2V
☐ 73620 - Foot 2V
☐ 73650 - Calcaneus min 2V
☐ 73660 - Toes min 2V

ROUTINE OB/GYN WOMEN'S HEALTH (PLEASE COMPLETE PROVIDER INFORMATION & √ SERVICE TYPE

OB/GYN Provider Name: _____

Address: _____

City, Zip Code: _____

Phone _____

☚ REVIEW CURRENT ROSTER *(MUST BE A CONTRACTED ST. VINCENT IPA PROVIDER)*

Service Type:
☐ 99203 –OB/GYN Consult
☐ 99213 - OB/GYN Follow-up
☐ 99395 - Well Women Exam (Annual) – Age 18-39
☐ 99396 - Well Women Exam (Annual) – Age 40-64
☐ 99397 - Well Women Exam (Annual) – Age >65

This requisition does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions. REV. 02.22.2021

HP AREA DIRECT REFERRAL REQUISITION FORM

ROUTINE OB/GYN WOMEN'S HEALTH (PLEASE COMPLETE PROVIDER INFORMATION &/ SERVICE TYPE

OB/GYN Provider Name: _____

Address: _____

City, Zip Code: _____

Phone: _____

REVIEW CURRENT ROSTER *(MUST BE A CONTRACTED ST. VINCENT IPA PROVIDER)*

Service Type:

☐ 99203 –OB/GYN Consult ☐ 99395 - Well Women Exam (Annual) – Age 18-39 ☐ 99397 - Well Women Exam (Annual) – Age >65

☐ 99213 – OB/GYN Follow-up ☐ 99396 - Well Women Exam (Annual) – Age 40-64

HP AREA DIRECT REFERRAL REQUISITION FORM

St. Vincent IPA c/o Physicians DataTrust, Inc.
P. O. Box 5089 Oceanside, CA 92052
Phone: (562) 860-8771/Fax: (562) 924-1453

Date of Referral Request: ____/____/____

Patient Name (First, MI, Last): _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Phone: (____) _____ Patient ID #: _____

Health Plan: _____

Referring Physician: _____ Referring Physician Signature: _____

Referring Physician Phone: (____) _____ Referring Physician Fax: (____) _____

Diagnosis (must be listed): _____

NOTICE TO PATIENT: Your primary care physician has approved your visit to the provider/specialist listed below. Please call the phone number listed below to make an appointment for mammography screening, CT Sinus Survey, and routine OB/GYN services on this form. Walk-in appointments are accepted for all other X-Ray services on this form.

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X-RAY (PLEASE √ LOCATION AND SERVICE TYPE)

☐ **Renaissance Imaging Los Angeles**
500 South Virgil Ave.
Los Angeles, CA 0017
Tel: 323-375-3945

☐ **Radnet - Zoe Huntington Park Advanced Imaging**
2679 Zoe Ave.
Huntington Park CA 90255
Tel: 323-584-3333

☐ **UMI of Maywood**
4316 E. Slauson Ave. Maywood, CA 90270
Tel: 323-374-6200

☐ **Radnet Huntington Park Advanced Imaging**
2680 Saturn Ave. Ste. 100
Huntington Park CA 90255
Tel. 323-584-3333

X-RAY TYPE: ***CPT CODES NOT LISTED REQUIRE SUBMISSION OF ROUTINE REFERRAL FORM***

HEAD & NECK
- ☐ 70250 - Skull <4V
- ☐ 70486-CT Sinus Survey

CHEST
- ☐ 71045 –1V
- ☐ 71046 –2V
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- ☐ 71120 - Sternum Min 2V

SPINE & PELVIS
- ☐ 72040-Spine Cervical 2 or 3V
- ☐ 72070-Spine Thoracic 2V
- ☐ 72100-Spine Lumbosacral 2-3V
- ☐ 72170 -Pelvis 1V
- ☐ 72220-Sacrum & coccyx min 2V

MAMMOGRAPHY
- ☐ 77067 Mammography Screening: Digital (age 40+)

UPPER EXTREMITIES
- ☐ 73030 - Shoulder min 2V
- ☐ 73070 - Elbow 2V
- ☐ 73090 - Forearm 2V
- ☐ 73100 - Wrist 2V
- ☐ 73120 - Hand 2V
- ☐ 73140 - Fingers min 2V

ABDOMEN
- ☐ 74018-anteroposterior 1V

LOWER EXTREMITIES
- ☐ 73502 - Hip unilateral min 2V
- ☐ 73521 - Hip bilateral min 2V
- ☐ 73552 – Femur 2V
- ☐ 73560 - Knee 1 or 2V
- ☐ 73590 - Tibia & Fibula 2V
- ☐ 73600 - Ankle 2V
- ☐ 73620 - Foot 2V
- ☐ 73650 - Calcaneus min 2V
- ☐ 73660 - Toes min 2V

ROUTINE OB/GYN WOMEN'S HEALTH (PLEASE COMPLETE PROVIDER INFORMATION & √ SERVICE TYPE)

OB/GYN Provider Name: _____

Address: _____

City, Zip Code: _____

Phone: _____

* REVIEW CURRENT ROSTER *(MUST BE A CONTRACTED ST. VINCENT IPA PROVIDER)*

Service Type:
- ☐ 99203 –OB/GYN Consult
- ☐ 99213 - OB/GYN Follow-up
- ☐ 99395 - Well Women Exam (Annual) – Age 18-39
- ☐ 99396 - Well Women Exam (Annual) – Age 40-64
- ☐ 99397 - Well Women Exam (Annual) – Age >65

This requisition does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions. REV. 3/7/18

INGLEWOOD AREA DIRECT REFERRAL REQUISITION FORM

St. Vincent IPA c/o Physicians DataTrust, Inc.
P. O. Box 5089 Oceanside, CA 92052
Phone: (562) 860-8771/Fax: (562) 924-1453

Date of Referral Request: _____/_____/_____

Patient Name (First, M, Last): _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Phone: (_____) _____ Patient ID #: _____

Health Plan: _____

Referring Physician: _____ Referring Physician Signature: _____

Referring Physician Phone: (_____) _____ Referring Physician Fax: (_____) _____

Diagnosis ***(must be listed)***: _____

NOTICE TO PATIENT: Your primary care physician has approved your visit to the provider/specialist listed below. Please call the phone number listed below to make an appointment for mammography screening, CT Sinus Survey, and routine OB/GYN services on this form. Walk-in appointments are accepted for all other X-Ray services on this form.

PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT.

NOTICE TO SPECIALIST: The above-listed patient has been referred to you for the procedure indicated.

X-RAY (PLEASE √ LOCATION AND SERVICE TYPE)

☐ **Renaissance Imaging Center Virgil**
500 S. Virgil Ave.
Suite 102
Los Angeles, CA 90020
Tel: 323-375-3940
Fax: 323-375-3945

☐ **UMI of Torrance**
3640 Lomita Blvd.
Suite 105
Torrance, CA 90505
Tel: 310-802-7000

☐ **UMI of Inglewood**
110 S. La Brea Ave.
Suite #150
Inglewood, CA 90301
Tel: 310-671-6000

☐ **UMI of Gardena**
1141 W. Redondo Beach Blvd.
Suite #105
Gardena, CA 90247
Tel: 310-436-1730

X-RAY TYPE: *****CPT CODES NOT LISTED REQUIRE SUBMISSION OF ROUTINE REFERRAL FORM*****

HEAD & NECK
☐ 70250 - Skull <4V
☐ 70486-CT Sinus Survey

CHEST
☐ 71045 – 1V
☐ 71046 – 2V
☐ 71100 - Ribs Uni 2V
☐ 71120 - Sternum Min 2V

SPINE & PELVIS
☐ 72040-Spine Cervical 2 or 3V
☐ 72070-Spine Thoracic 2V
☐ 72100-Spine Lumbosacral 2-3V
☐ 72170 -Pelvis 1V
☐ 72220-Sacrum & coccyx min 2V

MAMMOGRAPHY
☐ 77067 Mammography Screening, Digital (age 40+)

UPPER EXTREMITIES
☐ 73030 - Shoulder min 2V
☐ 73070 - Elbow 2V
☐ 73090 - Forearm 2V
☐ 73100 - Wrist 2V
☐ 73120 - Hand 2V
☐ 73140 - Fingers min 2V

ABDOMEN
☐ 74018-anteroposterior 1V

LOWER EXTREMITIES
☐ 73502 - Hip unilateral min 2V
☐ 73521 - Hip bilateral min 2V
☐ 73552 – Femur 2V
☐ 73560 - Knee 1 or 2V
☐ 73590 - Tibia & Fibula 2V
☐ 73600 - Ankle 2V
☐ 73620 - Foot 2V
☐ 73650 - Calcaneus min 2V
☐ 73660 - Toes min 2V

ROUTINE OB/GYN WOMEN'S HEALTH (PLEASE COMPLETE PROVIDER INFORMATION & √ SERVICE TYPE

OB/GYN Provider Name: _____

Address: _____

City, Zip Code: _____

Phone _____

➧ REVIEW CURRENT ROSTER *(MUST BE A CONTRACTED ST. VINCENT IPA PROVIDER)*

Service Type:
☐ 99203 –OB/GYN Consult
☐ 99213 - OB/GYN Follow-up
☐ 99395 - Well Women Exam (Annual) – Age 18-39
☐ 99396 - Well Women Exam (Annual) – Age 40-64
☐ 99397 - Well Women Exam (Annual) – Age >65

This requisition does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual

INGLEWOOD AREA DIRECT REFERRAL REQUISITION FORM

ROUTINE OB/GYN WOMEN'S HEALTH (PLEASE COMPLETE PROVIDER INFORMATION & // SERVICE TYPE

OB/GYN Provider Name: _____

Address: _____

City, Zip Code: _____

Phone: _____

☞ REVIEW CURRENT ROSTER *(MUST BE A CONTRACTED ST. VINCENT IPA PROVIDER)*

Service Type:

☐ 99203 - OB/GYN Consult ☐ 99395 - Well Women Exam (Annual) – Age 18-39 ☐ 99397 - Well Women Exam (Annual) – Age >65

☐ 99213 - OB/GYN Follow up ☐ 99396 - Well Women Exam (Annual) – Age 40-64

WEST LA DIRECT REFERRAL REQUISITION FORM

St. Vincent IPA c/o Physicians DataTrust, Inc.
P. O. Box 5089 Oceanside, CA 92052
Phone: (562) 860-8771/Fax: (562) 924-1453

Date of Referral Request: ____/____/____

Patient Name (First, MI, Last): _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: ____/____/____ Phone: (____) _____ Patient ID #: _____

Health Plan: _____

Referring Physician: _____ Referring Physician Signature: _____

Referring Physician Phone: (____) _____ Referring Physician Fax: (____) _____

Diagnosis (must be listed): _____

NOTICE TO PATIENT: Your primary care physician has approved your visit to the provider/specialist listed below. Please call the phone number listed below to make an appointment for mammography screening, CT Sinus Survey, and routine OB/GYN services on this form. Walk-in appointments are accepted for all other X-Ray services on this form.

PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT.

NOTICE TO SPECIALIST: The above-listed patient has been referred to you for the procedure indicated.

X-RAY (PLEASE ✓ LOCATION AND SERVICE TYPE)

☐ **Renaissance Imaging Center Virgil**
500 S. Virgil Ave.
Suite 102
Los Angeles, CA 90020
Tel: 323-375-3940
Fax: 323-375-3945

☐ **UMI of Los Angeles**
1127 Wilshire Blvd.
#100
Los Angeles, CA 90017
Tel: 213-223-5000

☐ **Beverly Tower Wilshire Advanced Imaging**
8750 Wilshire Blvd.
Suite 100
Beverly Hills, CA 90211
Tel: 310-689-3100

☐ **Radnet-Los Angeles Wilshire Downtown Advanced Imaging Center**
3055 Wilshire Blvd, Suite 150
Los Angeles, CA 90010
Tel: 213-487-4877

X-RAY TYPE: ***CPT CODES NOT LISTED REQUIRE SUBMISSION OF ROUTINE REFERRAL FORM***

HEAD & NECK
☐ 70250 - Skull <4V
☐ 70486 - CT Sinus Survey

CHEST
☐ 71045 – 1V
☐ 71046 – 2V
☐ 71100 - Ribs Uni 2V
☐ 71120 - Sternum Min 2V

SPINE & PELVIS
☐ 72040 - Spine Cervical 2 or 3V
☐ 72070 - Spine Thoracic 2V
☐ 72100 - Spine Lumbosacral 2-3V
☐ 72170 - Pelvis 1V
☐ 72220 Sacrum & coccyx min 2V

MAMMOGRAPHY
☐ 77067 Mammography Screening, Digital (age 40+)

UPPER EXTREMITIES
☐ 73030 - Shoulder min 2V
☐ 73070 - Elbow 2V
☐ 73090 - Forearm 2V
☐ 73100 - Wrist 2V
☐ 73120 - Hand 2V
☐ 73140 - Fingers min 2V

ABDOMEN
☐ 74018 - anteroposterior 1V

LOWER EXTREMITIES
☐ 73502 - Hip unilateral min 2V
☐ 73521 - Hip bilateral min 2V
☐ 73552 – Femur 2V
☐ 73560 - Knee 1 or 2V
☐ 73590 - Tibia & Fibula 2V
☐ 73600 - Ankle 2V
☐ 73620 - Foot 2V
☐ 73650 - Calcaneus min 2V
☐ 73660 - Toes min 2V

ROUTINE OB-GYN WOMEN'S HEALTH (PLEASE COMPLETE PROVIDER INFORMATION & ✓ SERVICE TYPE)

OB/GYN Provider Name: _____ ➔ REVIEW CURRENT ROSTER (MUST BE A CONTRACTED ST. VINCENT IPA PROVIDER)

Address: _____

City, Zip Code: _____

Phone: _____

Service Type:
☐ 99203 - OB/GYN Consult ☐ 99395 - Well Women Exam (Annual) - Age 18-39 ☐ 99397 - Well Women Exam (Annual) - Age >65
☐ 99213 - OB/GYN Follow-up ☐ 99396 - Well Women Exam (Annual) - Age 40-64

This requisition does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitations, provisions and exclusions. REV. 01.14.2021

WEST LA DIRECT REFERRAL REQUISITION FORM

ROUTINE OB/GYN WOMEN'S HEALTH /PLEASE COMPLETE PROVIDER INFORMATION & / SERVICE TYPE

OB/GYN Provider Name: _____

Address: _____

City, Zip Code: _____

Phone: _____

➔ **REVIEW CURRENT ROSTER** ***(MUST BE A CONTRACTED ST. VINCENT IPA PROVIDER)***

Service Type:

☐ 99203 –OB/GYN Consult ☐ 99395 - Well Women Exam (Annual) – Age 18-39 ☐ 99397 - Well Women Exam (Annual) – Age >65

☐ 99213 - OB/GYN Follow up ☐ 99396 - Well Women Exam (Annual) – Age 40-64

INJECTABLE REFERRAL FORM

St. Vincent IPA Medical Corporation
Fax: (562) 924-1453
Phone: (562) 860-8771

APPLICABLE COPAY	AUTHORIZATION NUMBER

DateofReferralRequest:1 /1 /1 ☐ Emergent ☐ Routine ☐ Urgent

Patient Name (First, MI, Last): _____
Address: _____ City: _____ ST: _____ Zip: _____
Date of Birth: / / Phone: _____ Patient ID#: _____
Health Plan: _____

Referred From:
MD Office Contact Name: _____
Provider Name: _____
PCP/Specialty: _____
Phone: _____
Fax: _____
SIGNATURE OF REFERRING PROVIDER:

_____
(Mandatory - Will not be processed without signature)

*Diagnosis: _____
*ICD 10: _____
Reason for Referral: _____
Additional notes attached: ☐ Yes ☐ No

If drug to be administered in office, office visit/administrative CPT code must accompany J code, if applicable.
Office Visit/Admin Code: _____

Drug Name:
J Code:
Dosage: _____
Duration of treatment: _____
Frequency: _____ Route: SQ IM

Drug Name: _____
J Code: _____
Dosage: _____
Duration of treatment: _____
Frequency: _____ Route : SQ IM

Drug Name: _____
J Code:
Dosage :
Duration of treatment :
Frequency : _____ Route : SQ IM

Drug Administered By:
☐ Home Health ☐ Patient ☐ Physician

Verbal notification to member of approval is required within 2 business days.
Member notified - Date:_____Time:_____Notified by:_____

- UM STAFF ONLY -

Benefits Verified By: _____
☐ Authorize Date _____ ☐ Pending Date _____
☐ Denied Date _____ ☐ Not a covered benefit.
☐ Modified Date _____
Comments: _____
_____
UM Signature: _____ Date: _____
Date PCP Notified: _____

Referred To:
Vendor: _____
Phone: _____ Fax: _____
Deliver To : _____
Address : _____
City: _____ ST: _____ Zip: _____
Phone: _____

Certification does not guarantee or confirm benefits will be paid. Payment of claims is subject to eligibility, contractual limitations provisions and exclusions. This certification is good for ninety (90) days from approval date.

ELIGIBILITY

Aerial Care
Member's Eligibility

Retrieve your member

Enter a members DOB (preferably)

Providing more than one search criteria can overload the search engine and not provide and result.

Your member's eligibility

Once a search criteria is entered a member name will be generated. The following icon will appear:

Red indicates the member is ineligible

Blue indicates member is eligible

If you have trouble finding the member look at their ID card to check if the health plan knows them by a different name or DOB: (Note: If the health plan has the patient information incorrectly, member must contact the health plan directly and make corrections. If you do not find your member and all the information is correct, contact the health plan directly and verify the member's eligibility.


Request for authorization extension
Eligibility Attestation – GTC-IPA

Patient Name _____

Auth # _____

Expiration date on auth _____

Request to extend auth to (date) _____

Reason for request _____

I understand that it is the responsibility of our office to check eligibility of the patient within two days of the service being rendered and to keep documentation of eligibility verification in the patient's file.

_____ Date _____

_____

Adding a New Member

Once the member's eligibility has been verified with the health plan, please fax an eligibility attestation form to **(562) 207-6511** in order to have the new member added to our database. Please allow 24 hours for the member to appear on the on-line portal.

Sample Eligibility List

MEMBER ID	LAST NAME	FIRST NAME	BIRTH DATE	SEX	EFFECTIVE DATE	Health Plan	ADDRESS	CITY	ZIP	TELEPHONE
123456-01	Doe	John	1/1/1960	M	1/1/2012	Blue Shield	123 Main St.	Los Angeles	90057	213-555-5555
654321-01	Smith	Jane	1/1/1940	F	1/1/2011	SCAN	111 Clark St.	Los Angeles	90026	213-444-4444

CLAIMS

Appeals

Appeals for St. Vincent IPA can be mailed to:

St. Vincent IPA
Attn: Appeals
PO BOX 5089
Oceanside, CA 92052

Fax to (760) 631-7614

Claims

Claim Electronic Submission Options: Aerial Care

There are two options for claims submission via Aerial Care:

- File upload, which allows for the upload of an ANSI837 Professional Claim file.
- Online Claim Entry, which is claim submission via manual entry into an Online CMS1500 Claim form.

File Upload

Access: Contact Medecision / Aerial Care for access at (800) 864-8160. Select the option for "Aerial Care Coordination".

Test File Submission: You must first submit a Test file before actual claims can be submitted. To upload a Test file, contact Support at (800) 864-8160 and select the option for "Aerial Care Coordination". A representative will assist you to ensure a successful Test File upload.

Claim File Submission: Once you have successfully submitted a Test file, you can submit a Claim file by clicking the Upload Claim Batches option, which is listed under Quick Links on the left side of your Aerial Care dashboard screen.

Submission Status: You can check the status of any submitted batch by clicking the Submitted Claim Batches option under Quick Links on the left side of your Aerial Care dashboard screen.

Error Correction: From the Submitted Claim Batches screen you can open any batch that has 1 or more listed in the Err field, meaning there are Errors. You can open the claim record and make the corrections on the online claim form.

Online Claim Entry

Access: Contact Medecision / Aerial Care for access at (800) 864-8160. Select the option for "Aerial Care Coordination".

Claim Entry: Click the Submit Online Claims option, which is listed under Quick Links on the left side of your Aerial Care dashboard screen. Enter the information on the search screen to locate the correct member. Click the Claim icon to create an online claim. Enter all applicable values. If you have only 1 claim to submit, click Submit Single Claim. If you have multiple claims to submit click Save in New Batch. Once all claims have been created and saved, click Submit Batch.

Submission Status: You can check the status of any submitted batch by clicking the Submitted Claim Batches option under Quick Links on the left side of your Aerial Care dashboard screen.

Error Correction: From the Submitted Claim Batches screen you can open any batch that has 1 or more listed in the Err field, meaning there are Errors. You can open the claim record and make the corrections on the online claim form.

Other Important Information:

- Member and Provider information in Aerial Care is updated nightly.
- Claims successfully submitted via Aerial Care are received by the IPA the following business day.
- Only Professional Claims or Encounters may be submitted via Aerial Care.

Claims

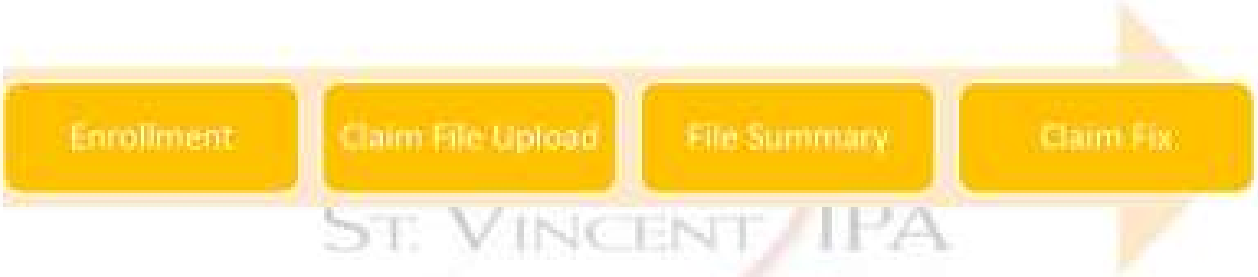
Claim Electronic Submission Options: Office Ally

There are two options for claims submission via Office Ally:

- File upload, which allows for the upload of an ANSI837 Professional or Institutional Claim file, either via web portal or SFTP.
- Online Claim Entry, which is claim submission via manual entry into an Online CMS1500 or UB04 Claim form.

Payer ID: PDT01

File Upload



Enrollment: Contact Office Ally for enrollment and access at (360) 975-7000. Select option 1. Or visit https://cms.officeally.com/Register/Register.aspx to complete the Enrollment Form online.

Claim File Upload: Log onto officeally.com. Hover over the Upload Claims option on the left side of the screen. Select Upload HCFA, to upload a Professional Claim file, or select Upload UB04 to upload an Institutional Claim file. Click Select File. Browse for your file and click Open. Click Upload. You will receive an upload confirmation page with your File ID number. Alternately, Office Ally does offer an option for SFTP file submission. Contact Office Ally at (360) 975-7000, option 1 to request SFTP. You will need to be prepared to provide the following information: Office Ally User Name, Contact Name, Email, Software Name, Format being submitted and whether you would like to receive 999/277s.

File Summary: Within 24 hours, your file summary will be available. This report is the receipt of the claims submitted. To view the available reports, select Download File Summary under Download listed on the left side of the screen. Dates listed with a pink background are dates that have reports that have not yet been viewed. Click on the date to view the available reports for that date. Click on the View link to review the report. Then click Open.

Claim Fix: If a claim receives an error and cannot be processed it will be made available in Claim Fix. You can view any claims in Claim Fix by selecting the Claim Fix option on the left side of your screen then clicking "Repairable Claims". Click on any date which has a

pink background. Click the Correct link to view and fix the data on the claim. Click Update to save the changes and resubmit the claim. Once all of your claims for a specific date have been corrected the background for that date will change to white.

Online Claim Entry

Enrollment: Contact Office Ally for enrollment and access at (360) 975-7000. Select option 1. Or visit https://cms.officeally.com/Register/Register.aspx to complete the Enrollment Form online.

Claim Entry: To view a detailed video which will walk you through the process, log onto the Office Ally Website at www.officeally.com. Click on Training Videos on the Menu Bar and then select the "Online Claim Entry" video under Service Center. To submit your claim(s) via Online Claim Entry, click the Online Claim Entry option under Claims, on the left side of your Office Ally screen, after you have logged onto the site.

Claim Batching: After online claims are submitted they will be "Awaiting Batch". Claims can take 1-3 hours to be reviewed and batched. While a claim is in this status you can view, edit or delete the claim by selecting Claims Awaiting Batch under the Online Claim Entry option on the left side of the screen.

File Summary: Within 24 hours, your file summary will be available. This report is the receipt of the claims submitted. To view the available reports, select Download File Summary under Download listed on the left side of the screen. Dates listed with a pink background are dates that have reports that have not yet been viewed. Click on the date to view the available reports for that date. Click on the View link to review the report. Then click Open.

Claim Fix: If a claim receives an error and can not be processed it will be made available in Claim Fix. You can view any claims in Claim Fix by selecting the Claim Fix option on the left side of your screen then clicking "Repairable Claims". Click on any date which has a pink background. Click the Correct link to view and fix the data on the claim. Click Update to save the changes and resubmit the claim. Once all of your claims for a specific date have been corrected the background for that date will change to white.

Other Important Information:

- Member and Provider information on Office Ally is updated weekly.

- Claims submitted via Office Ally are received by the IPA the business day after successful submission and processing by Office Ally.
- Office Ally offers to Print and mail any claims that cannot be submitted electronically. If you are interested in this service contact Office Ally or access the "Update Printing Option Form" available on the Office Ally website under Resource Center, Office Ally Forms & Manuals then Account Management.
- Technical Support is available at (375) 975-7000, option 2.
- Office Ally offers Free Training. To utilize this service contact Office Ally at (360) 975-7000 Option 5.

Claims

Claim Electronic Submission Options: Smart Data Solutions

There are two options for claims submission via Smart Data Solutions

- File upload, which allows for the upload of an ANSI837 Professional or Institutional Claim file.
- Online Claim Entry, which is claim submission via manual entry into an Online CMS1500 or UB04 Claim form.

Payer ID: PDT01

File Upload

Access: Contact Smart Data Solutions (855)297-4436 to obtain access.

Claim File Submission: Once you have access to the SDS Quick Claim Portal, you can submit a Claim file by clicking the Upload New File option.

Submission Status: You can check the status of any submitted batch by clicking on Batch History on the Main screen.

Error Correction: From main screen you can click on View Rejected documents, to review and correct any claims that were rejected.

Online Claim Entry

Access: Contact Smart Data Solutions (855)297-4436 to obtain access.

Claim Entry: Once you have access to the SDS Quick Claim Portal, you can submit a Claim online by clicking the Key New Claim option. Enter your claim information and click Save.

Submission Status: You can check the status of any submitted batch by clicking Batch History on the Main screen. Error Correction: From main screen you can click on View Rejected documents, to review and correct any claims that were rejected.

Other Important Information:

- Member and Provider information with Smart Data Solutions Aerial Care is updated every Friday.
- Claims successfully submitted via Smart Data Solutions are received by the IPA the following business day.
- Both Professional and Institutional Claims can be submitted via SDS.

Claims

Claim Submission: Paper Claims

Paper claims are scanned for optimal processing and recording of data provided; therefore, even paper claims must be legible and provided in the appropriate format to ensure scanning capabilities. The following paper claim submission requirements can speed claim processing and prevent delays:

- Use the appropriate form type for submission
- Use black or blue ink; do not use red ink, as the scanner may not be able to read it
- Use the Remarks field for messages
- Do not stamp or write over boxes on the claim form
- Send the original claim form to us and retain the copy for your records
- Separate each individual claim form. Do not staple original claims together, as we would consider the second claim an attachment and not an original claim to be processed separately
- Information is typed within the designated area of the field. Be sure the type falls completely within the text space and is properly aligned with corresponding information. If using a dot matrix printer, do not use draft mode since the characters generally do not have enough distinction and clarity for the optical character reader to accurately determine the contents

All paper claims should be mailed to the following address:

St. Vincent IPA
Attn: Claims Department
PO Box 5089
Oceanside, CA 92052

Claims

EFT/ How to Submit Payment

St. Vincent IPA has partnered with InstaMed, the leading healthcare payments network, to offer a free solution to deliver your payments as Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT). You can register to receive St. Vincent IPA ERA/EFT payments today at www.instamed.com/eraeft.

ERA/EFT is a convenient, paperless and secure way to receive claim payments. Funds are deposited directly into your designated bank account. The benefits of ERA/EFT include:

- Accelerated access to funds with direct deposit into your existing bank account
- Reduced administrative costs by eliminating paper checks and remittances
- No disruption to your current workflow – there is an option to have ERAs routed to your existing clearinghouse

You have two simple options to register to receive St. Vincent IPA payments as free ERA/EFT transactions:

1. **Online**: visit www.instamed.com/eraeft
2. **Paper**: complete the enclosed Network Funding Agreement and fax it to (877) 755-3392

All electronic payments and EOB's will be provided by InstaMed. This includes providers that sign up for electronic payment as well as those providers that did not sign up. For those providers that do not sign up, hard copy checks and EOB's will be mailed from InstaMed instead of PDT.

This notice was mailed to all PCP's however it is important to note that "Capitation Payment" will not be paid electronically. InstaMed will provide hard copy checks and remittance advise (RA's) to all PCP's .

PCP's can sign up to receive FFS payment electronically.

Please do not hesitate to contact us directly at (866) 945-7990 or connect@instamed.comwith any questions.

Claims

Frequently Asked Questions

1. **Is Online Registration secure?**
   Yes. InstaMed places the highest importance on data integrity, security and compliance. InstaMed meets the highest industry standards for compliance and security, including Payment Card Industry (PCI) Level One and verification processes to prevent fraud. For details about InstaMed compliance standards, visit www.instamed.com/about/compliance-and-security.

2. **What information is needed during Online Registration?**
   - Tax ID
   - Email Address
   - Legal Business Name
   - Business Address/Phone
   - Principal Name (primary decision maker)
   - Billing NPI Number
   - Bank Name
   - Bank Routing Number

3. **How will I receive my ERAs?**
   You have multiple options to receive your ERAs. Upon registering for InstaMed, you will receive access to InstaMed Online, a free, secure provider portal that will allow you to access payment details 24/7 and view and print remittances. You also have the option to have ERAs routed to your existing clearinghouse. Finally, you have the option to have an SFTP folder set up. Please contact InstaMed at connect@instamed.com or (866) 945-7990 with any questions on ERA delivery.

4. **Will I still receive paper EOBs in the mail?**
   No. Once your register for ERA/EFT, you will stop receiving paper checks and mailed EOPs.

5. **How will I know when I get paid?**
   You will receive email alerts to notify you when a payment is made, so you can easily track all payments. Additionally, you will have 24/7 access to reporting with InstaMed.

6. **Which NPIs do I provide?**
   Please enter your Type 2 NPI(s) during Online Registration since they are used for billing claims.

7. **What if I have multiple Tax IDs?**
   Once you register, you may add additional Tax IDs to your account.

8. **Who is the contact vs. the principal?**
   The principal is the primary decision maker, i.e. director or owner. The contact is the person who will be the administrator on the account. The contact may be the principal or an authorized representative of the organization.

9. **Which email address should I enter during Online Registration?**
   InstaMed will send an email to this address to confirm registration, so this should be an email address you want to use for your InstaMed account.

10. **Why do I need to enter details about my business during Online Registration, including date established?**
    In order to prevent fraud, we use this information to verify your organization.

11. **What is the turnaround time between registering online and receiving payments?**
    After you register online, it takes about 8 to 10 business days to receive your first payment, because InstaMed completes a thorough verification process to ensure your bank account information is secure.

12. **I'm a billing service. Why should I register?**
    We work directly with you, the billing service, enabling you to manage payments for your providers as you do today, but with tools to make your processes more efficient. Plus, you manage all of the payments and reports for providers all in one place, and enhance your offering to providers by enabling them to receive the payments faster.

Provider Claims Dispute Resolution Request

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- For routine follow-up, please use the Claims Follow-Up Form instead of the Provider Dispute Resolution Form.

Mail the completed form to **the appropriate IPA address listed on the attached sheet.**

*PROVIDER NAME:	*PROVIDER TAX ID # / Medicare ID #:
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ MD ☐ Mental Health ☐ Hospital ☐ ASC ☐ SNF ☐ DME

☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other

(please specify type of "other")

*** CLAIM INFORMATION** ☐ Single ☐ Multiple **"LIKE"** Claims (complete attached spreadsheet)

Number of claims:___

* Patient Name:	Date of Birth:

* Health Plan ID Number:	Patient Account Number:	Original Claim ID Number: (If multiple claims, use attached spreadsheet)

Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	Original Claim Amount Billed:	Original Claim Amount Paid:

DISPUTE TYPE

☐ Claim

☐ Seeking Resolution Of A Billing Determination

☐ Appeal of Medical Necessity / Utilization Management Decision

☐ Contract Dispute

☐ Request For Reimbursement Of Overpayment

☐ Other:

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print)	Title	( ) Phone Number
Signature	Date	( ) Fax Number

For Health Plan Use Only

TRACKING NUMBER

PROVIDER DISPUTE RESOLUTION REQUEST

(For use with multiple "LIKE" claims)

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT

Page _____ of _____

Number	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

Provider Dispute Resolution Request
Tracking Form

INSTRUCTIONS

- This optional form may be used to track the status, time-frames and disposition of the Provider Dispute Resolution.
- The entity processing the Provider Dispute Resolution should track the following information internally for ensuring compliance with regulations and for later reporting to the appropriate entity.

TRACKING NUMBER:	PROVIDER ID#:
a. PROVIDER NAME:	b. CONTRACTED PROVIDER: _____ YES _____ NO
c. DATE DISPUTE RECEIVED (Date Stamped):	d. DATE OF INITIAL PAYMENT OR ACTION:
e. WAS DISPUTE RECEIVED WITHIN TIMEFRAME? (c – d) _____YES _____ NO (If NO, should be returned to provider without action)	

f. DISPUTE TYPE:

☐ CLAIM ISSUE ☐ OVERPAYMENT REIMBURSEMENT REQUEST ☐ BILLING ISSUE

☐ CONTRACT ISSUE ☐ UM/MEDICAL NECESSITY ISSUE

☐ OTHER _____

(Please specify type of "other")

g. DATE DISPUTE ACKNOWLEDGED:	h. TURNAROUND TIME (g – c):

TYPE OF LETTER SENT: (List the various ICE letters as applicable)

IF NO ADDITIONAL INFORMATION REQUESTED:

j. DATE OF ACTION:	k. ACTION TURNAROUND TIME (j – c):	l. TYPE OF ACTION (Upheld, Denied, Partially Upheld):

IF ADDITIONAL INFORMATION REQUESTED:

m. DATE ADDITIONAL INFO REQUESTED:	n. TURNAROUND TIME (m – c):
o. DATE ADDITIONAL INFO RECEIVED:	p. RECEIPT TURNAROUND TIME (o – m):

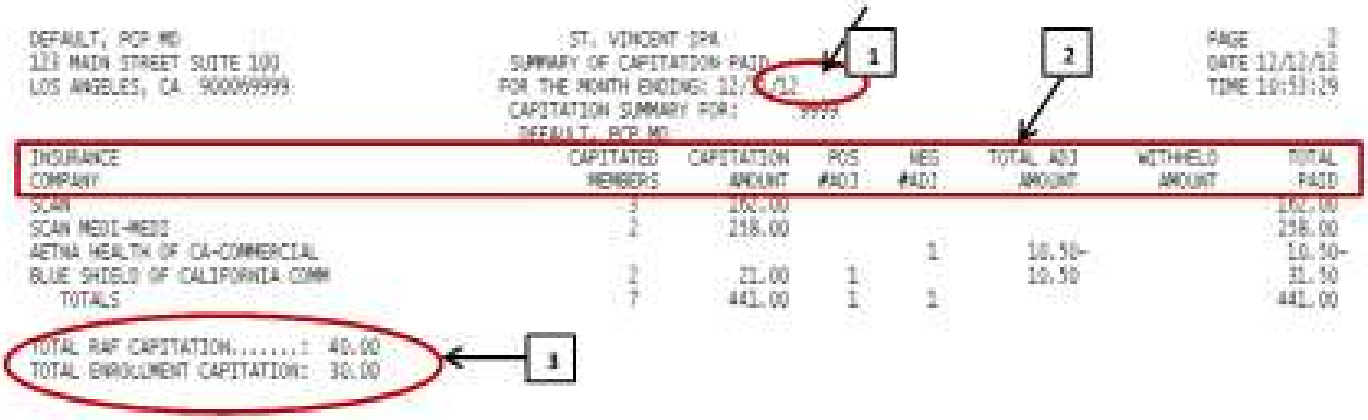
q. DATE OF ACTION:	r. ACTION TURNAROUND TIME (q – o):	s. TYPE OF ACTION (Upheld, Denied, Partially Upheld):

COMPLETE DESCRIPTION OF DETERMINATION RATIONALE:

CAPITATION REPORTS

How to Read Your Capitation Report

Summary Capitation Report



DEFAULT, PCP MD
123 MAIN STREET SUITE 100
LOS ANGELES, CA 900099999

ST. VINCENT IPA
SUMMARY OF CAPITATION PAID
FOR THE MONTH ENDING: 12/31/12
CAPITATION SUMMARY FOR: 9999
DEFAULT, PCP MD

PAGE 1
DATE 12/12/12
TIME 10:51:29

INSURANCE COMPANY	CAPITATED MEMBERS	CAPITATION AMOUNT	POS #ADJ	NEG #ADJ	TOTAL ADJ AMOUNT	WITHHELD AMOUNT	TOTAL PAID
SCAN	1	182.00					182.00
SCAN MEDI-MEDI	2	238.00					238.00
AETNA HEALTH OF CA-COMMERCIAL				1	10.50-		10.50-
BLUE SHIELD OF CALIFORNIA COMM	2	21.00	1		10.50		31.50
TOTALS	7	441.00	1	1			441.00

TOTAL RAF CAPITATION.....: 40.00
TOTAL ENROLLMENT CAPITATION: 30.00

1. **Capitation Paid for the Month Ending:** This date represents the last day of the month that capitation is being paid for.
2.
   a. **Insurance Company:** An abbreviation of the Health Plan Name.
   b. **Capitated Members:** The number of capitated members that are included in this month's capitation for the listed Insurance Company.
   c. **Capitation Amount:** The total capitation being paid for the listed Insurance Company, excluding any adjustments.
   d. **Pos #Adj:** The positive number of adjustments included in this month's capitation. For the listed Insurance Company.
   e. **Neg #Adj:** The negative number of adjustments included in this month's capitation, for the listed Insurance Company.
   f. **Total Adj Amount:** The total amount of capitation adjustments included in this month's capitation, for the listed Insurance Company.
   g. **Withheld Amount:** The total amount of capitation withheld from this month's capitation, for the listed Insurance Company.
   h. **Total Paid:** The total amount of capitation paid for the listed Insurance Company.
3.
   a. **Total RAF Capitation**: The total amount of capitation being paid as part of the RAF Adjusted Capitation Program.
   b. **Total Enrollment Capitation:** The total amount of capitation being paid as part of the Enrollment Adjusted Capitation program.

Capitation Research Request Form

Date: _____ PCP: _____

Contact: _____ Phone: _____ Fax: _____

The following members are effective with St. Vincent IPA per the health plan, but are not showing up on my capitation list. Please research and verify that the members are eligible for capitation payment.

Member Information: (Please print CLEARLY. All Information MUST be completed)

Member Name	Date of Birth	Health Plan	Member ID #	Months Cap Not Received
1.				
IPA USE ONLY:	Effective Date:		Comments:	
2.				
IPA USE ONLY:	Effective Date:		Comments:	
3.				
IPA USE ONLY:	Effective Date:		Comments:	
4.				
IPA USE ONLY:	Effective Date:		Comments:	
5.				
IPA USE ONLY:	Effective Date:		Comments:	
6.				
IPA USE ONLY:	Effective Date:		Comments:	
7.				
IPA USE ONLY:	Effective Date:		Comments:	
8.				
IPA USE ONLY:	Effective Date:		Comments:	
9.				
IPA USE ONLY:	Effective Date:		Comments:	
10.				
IPA USE ONLY:	Effective Date:		Comments:	

FAX REQUEST TO: (562) 924-1603 **ATTN:** PROVIDER RELATIONS

*__Note:__ Once eligibility has been verified, capitation will be paid retroactive from date of notification.

RISK ADJUSTMENT & QUALITY

Tips for Completing Your Annual Visit (AV) Form

Please follow these guidelines to help ensure that your AV forms are submitted as completely and accurately as possible:

- Send AV's to- Fax (562) 207-6508 or email riskadjustment@pcdtrust.com

- Please complete the top section of the AV form, which includes the patient's height, weight, BMI, heart rate, blood pressure, date of last flu vaccine, date of last bone density test if known, patient's chief complaint, patient's history and present illness (HPI).

- Please check Yes/No for each medical condition listed on the AV Form.
  - If Yes is checked, please document the condition. All acute and chronic diagnoses must be fully documented with current status. If you prefer, you can also attach your progress notes.

- A treatment plan for each medical condition must be provided.

- Please assess the patient for the HCCs that appear on the HCC history and HCC suspect section of the form. The Yes/No box for each of these conditions must be checked, documentation, details and treatment plan must be included. Please note that if a Senior patient is new to St. Vincent IPA, the HCC history and/or HCC suspect information may not be available.

- Physician signature, physician credentials, and date of service must be included on each page.

- The AV Form must be complete and legible and only standard medical abbreviations may be used.

- Failure to provide any of the information noted above may result in your AV form being pended, which will affect the compensation received for the form.

When completing the depression section of the form, please include dates and results of PHQ-9 screening. If this section is not completed for a major depression diagnosis, the AV form will be pended for this information. The PHQ-9 does not have to be submitted with your AV form this year but must be maintained in the patient's medical chart.

Medicare Risk Adjustment Factor (RAF)

The purpose for the Centers for Medicare and Medicaid Services (CMS) to conduct Risk Adjustment Factors is to pay plans for the risk of the beneficiaries they enroll, instead of calculating an average amount of Medicare/Medicare Advantage beneficiaries. By doing so, CMS is able to make appropriate and accurate payments for enrollees with differences in expected costs. Lastly, the risk adjustment allows CMS to use standardized bids as base payments to plans.

CMS risk adjusts certain plan payments, such as Part C payments made to Medicare Advantage (MA) plans and Program for All Inclusive Care for The Elderly (PACE) organizations, and Part D payments made to Part D sponsors, including Medicare Advantage-Prescription Drug plans (MA-PDs) and standalone Prescription Drug Plans (PDPs).

Below is a high-level checklist of plan requirements with detailed information regarding risk adjustment data collection, submission, reporting, and validation:

- "Ensure the accuracy and integrity of risk adjustment data submitted to CMS. All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit.
- Implement procedures to ensure that diagnoses are from acceptable data source. The only acceptable data sources are hospital inpatient facilities, hospital outpatient facilities, and physicians.
- Submit the required data elements from acceptable data sources according to the coding guidelines.
- Submit all required diagnoses codes for each beneficiary and submit unique diagnoses once during the risk adjustment data-reporting period. Submitters must filter diagnosis data to eliminate the submission of duplicate diagnosis clutters.
- The plan sponsor determines that any diagnosis codes have been erroneously submitted, the plan sponsor is responsible for deleting the submitted diagnosis codes as soon as possible.
- Receive and reconcile CMS Risk Adjustment Reports in a timely manner. Plan sponsors must track their submission and deletion of diagnosis codes on an ongoing basis.
- Once CMS calculates the final risk scores for a payment year, plan sponsors can only request a recalculation of payment upon discovering the submission of erroneous diagnosis codes that CMS used to calculate a final risk score for a previous payment year and that had a material impact on the final payment. Plan sponsors must inform CMS immediately upon such a finding."

Reference:
http://www.hhi.com/assets/forms/Medicare%20Managed%20Care%20Manual%20%28Risk%20Adjustment%29.pdf

HEDIS Coding Tip Sheet

St. Vincent IPA
The Patient's Choice for Health Care

CPT Category II codes are used for tracking data collection for the purposes of performance measurement. These codes are developed by the Performance Measures Advisory Group (PMAG). Using CPT II codes can ease the burden of chart review for HEDIS measures. These codes describe clinical components and are not associated with a billable amount, therefore, when used should be billed with a $0.01 charge amount.

CPT Category II Codes—By Measure

HEDIS Measure	CPT II Code	Description
Adult BMI	3008F	BMI Documented *See below for dx codes*
Care of Older Adults	1157F	Advance care plan (document) present in medical records
	1158F	Advance care planning discussion documented in records
	1170F	Function status assessed
	0521F	Plan of care to address pain documented
	1125F	Pain severity quantified, pain present
	1126F	Pain severity quantified, no pain present
	1159F	Medication list documented in medical record
	1160F	Review of all meds by prescriber documented in record
Cholesterol Mgmt.	3048F	Most recent LDL-C <100 mg/dL
	3049F	Most recent LDL-C 100-129 mg/dL
	3050F	Most recent LDL-C >=130 mg/dL
Controlling Blood Pressure	3074F	Most recent systolic blood pressure <130 mmHg
	3075F	Most recent systolic blood pressure 130-139 mm Hg
	3077F	Most recent systolic blood pressure >=140 mm Hg
	3078F	Most recent diastolic blood pressure <80 mm Hg
	3079F	Most recent diastolic blood pressure 80-89 mmHg
	3080F	Most recent diastolic blood pressure >=90 mm Hg
Comprehensive Diabetes	3044F	Most recent HbA1c level less than 7.0%
	3045F	Most recent HbA1c level between 7.0-9.0%
	3046F	Most recent HbA1c level greater than 9.0%
	2022F	Dilated retinal eye exam documented/reviewed
	2024F	7 standard filed stereoscopic photo documented/reviewed
	2026F	Eye imaging validated to match dx documented/reviewed
	3072F	Low risk for retinopathy

HEDIS Coding Tip Sheet

ST. VINCENT IPA
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CPT Category II Codes—By Measure (Cont.)

HEDIS Measure	CPT II Code	Description
Comprehensive Diabetes	3048F	Most recent LDL-C <100 mg/dL
	3049F	Most recent LDL-C 100-129 mg/dL
	3050F	Most recent LDL-C >=130 mg/dL
	3060F	Positive microalbuminuria test documented/reviewed
	3061F	Negative microalbuminuria test documented/reviewed
	3062F	Positive microalbuminuria test confirmed with lab result
	3066F	Documentation of tx for nephropathy
	4010F	ACEI or ARB therapy prescribed or currently taking
	3074F	Most recent systolic blood pressure <130 mmHg
	3075F	Most recent systolic blood pressure 130-139 mm Hg
	3077F	Most recent systolic blood pressure >=140 mm Hg
	3078F	Most recent diastolic blood pressure <80 mm Hg
	3079F	Most recent diastolic blood pressure 80-89 mmHg
	3080F	Most recent diastolic blood pressure >=90 mm Hg
Medication Management	1111F	Medication reconciliation post discharge

BMI Diagnosis Codes

BMI	Dx Code	BMI	Dx Code
Less 19	Z68.1	32.0-32.9	Z68.32
20.0-20.9	Z68.20	33.0-3.9	Z68.33
21.0-21.9	Z68.21	34.0-34.9	Z68.34
22.0-22.9	Z68.22	35.0-35.9	Z68.35
23.0-23.9	Z68.23	36.0-36.9	Z68.36
24.0-24.9	Z68.24	37.0-37.9	Z68.37
25.0-25.9	Z68.25	38.0-38.9	Z68.38
26.0-26.9	Z68.26	39.0-39.9	Z68.39
27.0-27.9	Z68.27	40.0-44.9	Z68.41
28.0-28.9	Z68.28	45.0-49.9	Z68.42
29.0-29.9	Z68.29	50.0-59.9	Z68.43
30.0-30.9	Z68.30	60.0-69.9	Z68.44
31.0-31.9	Z68.31	70-Over	Z68.45

Special Needs Plan (SNP)

CPT codes

CMS 5 Star measure "Care for Older Adults" states that any male or female 66+ on a ***Special Needs Plan*** must have (4) annual services performed every year.

These services also have very specific CPT II codes in which should be billed with your E&M code and require documentation in the patient medical record.

Please see below for CPT II details:

Service	CPT	Description
Medication List	1159F	Medication list documented in medical record
Medication Review	1160F	Review of all medications by a prescribing practitioner or clinical pharmacist documented in the medical record
Advanced Care Planning	1157F	Advance care plan or similar legal document present in the medical record
	1158F	Advance care planning discussion documented in the medical record
Functional Status Assessment	1170F	Functional status assessed. A minimum of (3) of the following to be assessed and documented in the • medical record: cognitive status, ambulation status, • sensory ability • function of independence
Pain Screening	1125F	Pain severity quantified 0-10; pain present
	1126F	No pain present

Homebound/High Risk Program and Diabetic/Wellness Clinic

St. Vincent IPA Homebound/ High Risk Program and **St. Vincent IPA Diabetic/Wellness Clinic** are designed to contribute and/or enhance the services you are rendering to your St. Vincent IPA patients. It is our hope that together we will better meet the health care needs and challenges of your patients, our members.

The purpose of these enhancements is three-fold:

(1) To improve the health and well-being of St. Vincent IPA patients

(2) To provide you with a complete H&P, problem list, medications list and other pertinent clinical information which will assist you in the ongoing management of your patients (this will be faxed to you after the evaluation is completed

(3) To assist our Nurse Practioner in identifying patients that may benefit from admission into the Homebound/ High Risk Program and or the Diabetic clinic

Candidates to the Programs will be identified by the IPA based on internal and health plan claims data and targets patients identified with one or more of the following:

- Potential or actual high risk health care problems/complex diagnoses
- Frequent emergency room visits
- Multiple hospitalizations and/or multiple re-admissions within a short period of time
- Frequent utilization of out-of- network facilities
- Require post-hospitalization follow-up until seen by their primary care provider
- Frail elderly at risk for requiring extensive outpatient and/or inpatient services
- Comprehensive education of your diabetic members
- Patients with gaps in their preventative care are identified in the 5star program

The process of Homebound/ High Risk Program is as follows:

1. Candidates for the Program will be identified by the IPA utilizing the above criteria.
2. If a patient is a candidate and admitted into the Program, the Primary Care Physician (PCP) will be contacted by mail. The PCP will continue to receive capitation for the patient. In order to maximize patient compliance and cooperation with the Program, the PCP must remain involved and serve as an advisor and facilitator to the Homebound/High Risk team while the patient is in the Program.
3. The patient will be contacted via phone by the nurse practitioner and an in-home appointment will be scheduled.

Acute health care needs, diagnoses or hospitalizations, complex medical issues and/or comorbidities, poorly controlled disease states, frequent admissions, multiple emergency department visits, and predictive modeling identified risk level. With one of the following needs: Adherence to treatment such as meds, md visits, behavior changes, diet, etc. Care coordination, patient education and activation, community resources.

We are available to assist you with your patients with ongoing case management for as long as the member has identified needs and expresses willingness to receive support and services from the program at no cost to them.

In an effort to maximize the success of these programs and continually improve the quality of service rendered, your assistance is requested in this team effort. Your assistance in providing us with any information that will enable us to achieve the best possible patient outcomes will be invaluable. Should you have any questions regarding this program, please do not hesitate to contact Leesa Johnson, Vice President of IPA Operations at (562) 860-8771 extension 108. You may also contact Cynthia Clegg, FNP at (213) 393-8402 or Adamma Epoh, FNP at (213) 628-6539 and for case management Cynthia Acker at 213-215-5217.

ST. VINCENT IPA

The Patient's Choice for Health Care

TAKE ADVANTAGE OF OUR DIABETES PROGRAM $0 COPAY

You and your health come first with St. Vincent IPA and it is important for you to have regular check-ups.

St. Vincent IPA understands that you have a busy schedule; in an effort to help you receive the best care, St. Vincent IPA has established a diabetic clinic to help you manage your diabetes. You also have the option to schedule a call to review and discuss management of your diabetic care.

In addition to providing routine diabetic services and education. Our Diabetic Nurse Educators will personally work with you to keep your diabetes under control.

Please contact (888) 387-8472 to schedule an appointment or a telephonic appointment. We encourage you to take advantage of these services.

OUR DIABETIC NURSES EDUCATORS WILL ASSIST YOU WITH THE FOLLOWING:

- Diabetic Exams/Check-ups
- Blood Sugar/ Cholesterol Monitoring
- Diabetic Foot Exams
- Nutritional Counseling
- Review of Medications
- Education on Exercise
- Pre-Diabetes

Diabetes Educators:
Cynthia Clegg, FNP
Adamma Epoh, FNP
ENGLISH & SPANISH

Diabetes Clinic
1931 W. Sunset Blvd
Los Angeles, CA 90026

COMPLIANCE

Physicians DataTrust

SUBCONTRACTOR PRIVACY/SECURITY REQUIREMENTS

Who must comply?

Organizations providing healthcare services or certain administrative services must uphold an individual's right to privacy. This means adhering to requirements set forth by the Centers for Medicare & Medicaid Services (CMS), HIPAA and the HITECH Act, the Gramm-Leach-Bliley Act, the IPA, and the IPA's affiliated health plans.

Under HIPAA, health plans, health care clearinghouses, and health care providers are considered **covered entities.**

Subcontractors that perform activities involving the use or disclosure of protected health information (PHI) are considered **business associates.** These activities include creating, receiving, maintaining, transmitting, processing, accessing, or storing PHI.

A covered entity may be a business associate of another covered entity.

Workforce members are employees, volunteers, trainees, and any other persons under the direct control of a covered entity or business associate, regardless of payment.

Your Responsibilities

As a business associate, the IPA is responsible to fulfill the terms and conditions in our contracts with covered entities, and to meet regulatory requirements for patient privacy and information security. As a subcontractor to the IPA, you are responsible to adhere to these requirements as well. This includes:

- Upholding the Business Associate Agreement (BAA) provisions set forth by the IPA,
- Ensuring your subcontractors also uphold these privacy and security standards.

You must keep evidence of your compliance with these requirements for at least 6 years. This may include employee training records, policies, risk assessments, documentation of privacy/security incidents, or proof of the way you oversee your subcontractors. You may be asked to complete an attestation or audit to verify your adherence to these requirements.

If you or your subcontractors fail to meet privacy and security requirements, it may lead to retraining, corrective actions, or other sanctions. If you discover a privacy or security issue, you must take quick action to fix and report the issue. And, you need to prevent it from happening again.

Privacy/Security Requirements

S-

Offshore Operations

Offshore operations refers to operations conducted outside of the United States or United States Territories. An offshore subcontractor provides services performed by workers located offshore. This includes:

The

- American-owned companies with operations performed outside of the United States
- Foreign-owned companies with operations performed outside of the United States

If any of your employees or subcontractors perform work offshore, and that offshore work includes receiving, processing, transferring, handling, storing, or accessing PHI on the IPA's behalf, you must notify Physicians DataTrust at compliance@pdtrust.com, or by phone at (562) 860-8771, ext. 114.

Physicians DataTrust may be required to report these operations to the IPA's affiliated health plans. And, Physicians DataTrust may require your organization to develop additional controls to ensure PHI is protected in the course of offshore business.

More information about offshore operations is available at https://pdtrust.com/compliance.

Privacy & Security Training

As a subcontractor to the IPA, your organization must maintain policies and procedures to uphold privacy and security requirements. And, you must train your workforce and business associate subcontractors on these policies and procedures, as necessary and appropriate for them to carry out their assigned duties in compliance with privacy and security requirements.

The policies, procedures, and training materials must include the requirement and the method(s) for workforce members and business associates to report privacy and security concerns. And, your policies and procedures must include a provision to report privacy and security concerns (that impact the IPA) to Physicians DataTrust without delay.

You must conduct this training prior to granting access to PHI, annually thereafter, and when there are changes to privacy and security policies. You must also save proof that you conducted the training. If you use training logs, reports, or sign-in sheets as evidence of completion, they must include names, dates, and training topics.

PDT Privacy/Security Training is available at https://pdtrust.com/compliance. You are not required to use these materials.

Subcontractor Oversight

As a subcontractor to the IPA, you must monitor the compliance of your business associate subcontractors. If you choose to subcontract with other parties for IPA business, you must make sure they abide by all requirements that apply to you as a subcontractor of the IPA. This includes ensuring:

- A written service agreement and BAA are in place prior to involvement with IPA business
- The business associate subcontractor complies with the requirements described in this guide
- The business associate subcontractor complies with all applicable privacy and security standards

PDT's BAA template is available at https://pdtrust.com/compliance. You are not required to use this BAA template.

Physicians DataTrust

SUBCONTRACTOR PRIVACY/SECURITY REQUIREMENTS

Not every subcontractor is a business associate. Only subcontractors that create, receive, maintain, transmit, process, store, or access PHI are considered business associates. The following types of subcontractors are not business associates:

- Housekeeping/custodial
- Grounds and maintenance
- Machine repair or servicing

For help identifying which of your subcontractors are business associates, please contact Physicians DataTrust at compliance@pdtrust.com, or by phone at (562) 860-8771, ext. 114.

L.A. Care and Medi-cal Requirements

Accreditation of Medi-Cal, Healthy Kids and Healthy Families Program.

The New Provider Orientation Handbook

L.A. Care HEALTH PLAN®

Revised: 10/14/15

LA1456 10/15

Dear L.A. Care Contracted Provider,

L.A. Care Health Plan (L.A. Care) has created this provider orientation handbook to ensure that your L.A. Care contracted Participating Provider Group (PPG) or Management Services Organization (MSO) has the necessary tools to train you, the Primary Care Physicians and/or Specialists, on the Medi-Cal Managed Care program and L.A. Care's policies and procedures.

According to L.A. Care's contract with the State of California's Department of Health Care Services, new contracted providers MUST be trained within 10 business days of active status.

The information provided will allow you and your staff to gain a broad understanding of L.A. Care's mission, the importance of positive customer service experiences, member benefits, and member rights and responsibilities. If you would like more information, please reference the L.A. Care Provider Manual by visiting **www.lacare.org**.

Additionally, if you need clarification on any of the information provided, please contact your PPG or MSO for further guidance.

Welcome to the L.A. Care Health Plan Network!

Table of Contents

L.A. Care's History

Established in 1997, L.A. Care is an independent local public agency created by the state of California to provide health coverage to low-income Los Angeles County residents. L.A. Care is the nation's largest publicly operated health plan. Serving more than 1.8 million members, our mission is to ensure our members get the right care at the right place at the right time. For more history and information on L.A. Care, please visit **www.lacare.org**.

L.A. Care's Delegated Model

L.A. Care delegates certain authorization and claims processing to some of its contracted Participating Provider Groups (PPGs) and Management Services Organizations (MSOs). Delegation is when an entity gives another entity the authority to carry out a function that it would otherwise perform, such as operating within the parameters agreed upon between the health plan and PPG/MSO.

The National Committee on Quality Assurance (NCQA) holds L.A. Care to the following requirements:

- Delegation Agreement - A mutual agreement between L.A. Care and its PPG/MSO outlining specific delegated functions that meet NCQA standards.
- Oversight and Monitoring – L.A. Care must oversee the delegates to ensure that the delegate is properly performing all delegated functions.

For more information on NQCA standards and functions, please visit their website at **http://www.ncqa.org/AboutNCQA.aspx**.

Medi-Cal Managed Care provides high quality, accessible, and cost-effective health care through managed care delivery systems. Medi-Cal Managed Care contracts for health care services through established networks of organized systems of care which emphasize primary and preventive care. Managed care plans like L.A. Care, have been proven to be a cost-effective use of health care resources that improve health care access and assure quality of care.

In order to determine who is responsible for paying a claim, please contact the members assigned PPG/MSO or reference your PPG/MSO contract for more information.

Timely Filing Deadline

L.A. Care cannot impose a timeframe for receipt of an 'initial claim' submission less than 90 days for contracted providers or 180 days for non-contracted providers after the date of service for timely filing for a new claim.

Billing

All paper claims must be submitted on CMS 1500 form for professional services and UB-04 form for facility services. L.A. Care accepts EDI submissions, please reference **http://www.lacare.org/providers/provider-resources/provider-forms**.

Claims Adjudication

Each claim is subject to a comprehensive series of quality checks called "edits" and "audits." Quality checks verify and validate all claim information to determine if the claim should be paid, denied or suspended for manual review. Edit and audit checks include verification of:

- Data validity
- Procedure and diagnosis compatibility
- Provider eligibility on date of service
- Recipient eligibility on date of service
- Medicare or other insurance coverage
- Claim duplication
- Authorization requirements

Provider Portal Claims Verification

- The L.A. Care Provider Portal is the preferred method for contracted providers to check claims status. Please see information on how to access the L.A. Care Provider Portal in the Provider Portal section of this handbook.
- The secondary method to check claims status is by calling 1-866-LA-CARE6.

Balanced Billing

Balance billing L.A. Care members is prohibited by law. Contracted providers cannot collect reimbursement from a L.A. Care member or persons acting on behalf of a member for any services provided, except to collect any authorized share of cost.

Provider Disputes

When the claim is the responsibility of the PPG/MSO, a provider dispute can be filed in writing with the PPG/MSO. Contact the PPG/MSO for more information on how to file a claims dispute. If the provider is dissatisfied with the resolution of the initial dispute filed with the PPG/MSO, a second level dispute may be filed with L.A. Care's Claims Provider Disputes unit. A copy of the PPG/MSO denial or Notice of Decision letter must fully describe the dispute and the PPGs/MSOs decision. The second level dispute must include a description of timelines as well as information to support the description of the dispute along with the claim.

Provider disputes must be submitted to:
L.A. Care Health Plan
Attention: Provider Disputes
P.O. Box 811610
Los Angeles, CA 90081

Authorizations

In order to determine who is responsible for authorization of services, please contact the members' assigned PPG/MSO or reference your contract with the PPG/MSO for more information.

Professional authorizations and payment of claims for those services are usually the responsibility of the PPG. For all other services, PPGs/MSOs and L.A. Care have a contractual document that defines which entity is responsible for a service (e.g., Division of Financial Responsibility and a Delegation Agreement). For additional information on what services are paid for by the PPG or L.A. Care, please call your PPG/MSO.

You can access the *Delegation Matrix* tool to identify which PPG is at risk for authorizing services by visiting **http://www.lacare.org/sites/default/files/Provider%20Authorization%20and%20Billing%20Guidance%2006%2017%2015.pdf**

A copy of L.A. Care's Authorization Request Form is available at: **http://www.lacare.org/sites/default/files/PL0022c_Updated_Auth_Req_Form_10%2001%202015_FINAL.pdf**

Services That Do Not Require Prior Authorization

- Emergency Services, whether in or out of L.A. County but within the continental USA (except for care provided outside of the United States which is subject to retrospective review)
- Emergency Care provided in Canada or Mexico is covered
- Urgent care, whether in or out of network
- Mental health care and substance use treatment
- Routine Women's health services – a woman can go directly to any network provider for women's health care such as breast or pelvic exams
  - This includes care provided by a Certified Nurse Midwife/OB-GYN and Certified Nurse Practitioners
- Basic prenatal care – a woman can go directly to any network provider for basic pre-natal care
- Family planning services, including: counseling, pregnancy tests and procedures for the termination of pregnancy (abortion)
- Treatment for Sexually Transmitted Diseases, includes: testing, counseling, treatment and prevention
- Emergency medical transportation

Services That May Require Prior Authorization

Note: As the Prior Authorization process may vary between PPGs/MSOs, verify with your contracted PPG/MSO that these services are correct.

- Non-emergency out of area care (outside of L.A. County)
- Out of network care, services not provided by a contracted network doctor
- Inpatient admissions, post-stabilization/non-emergency/elective
- Inpatient admission to skilled nursing facility or nursing home
- Outpatient hospital services/surgery
- Outpatient, non-hospital , such as surgeries or sleep studies
- Outpatient diagnostic services, minimally invasive or invasive such as CT Scans, MRIs, colonoscopy, endoscopy, flexible sigmoidoscopy, and cardiac catheterization

- Durable Medical Equipment, standard or customized; rented or purchased
- Medical Supplies
- Prosthetics and Orthotics
- Home Health Care, including: nurse aide, therapies, and social worker
- Hospice
- Transportation (excluding emergency medical transportation)
- Experimental or Investigation Services
- Cancer Clinical Trials

Hospital and Ancillary Provider Network

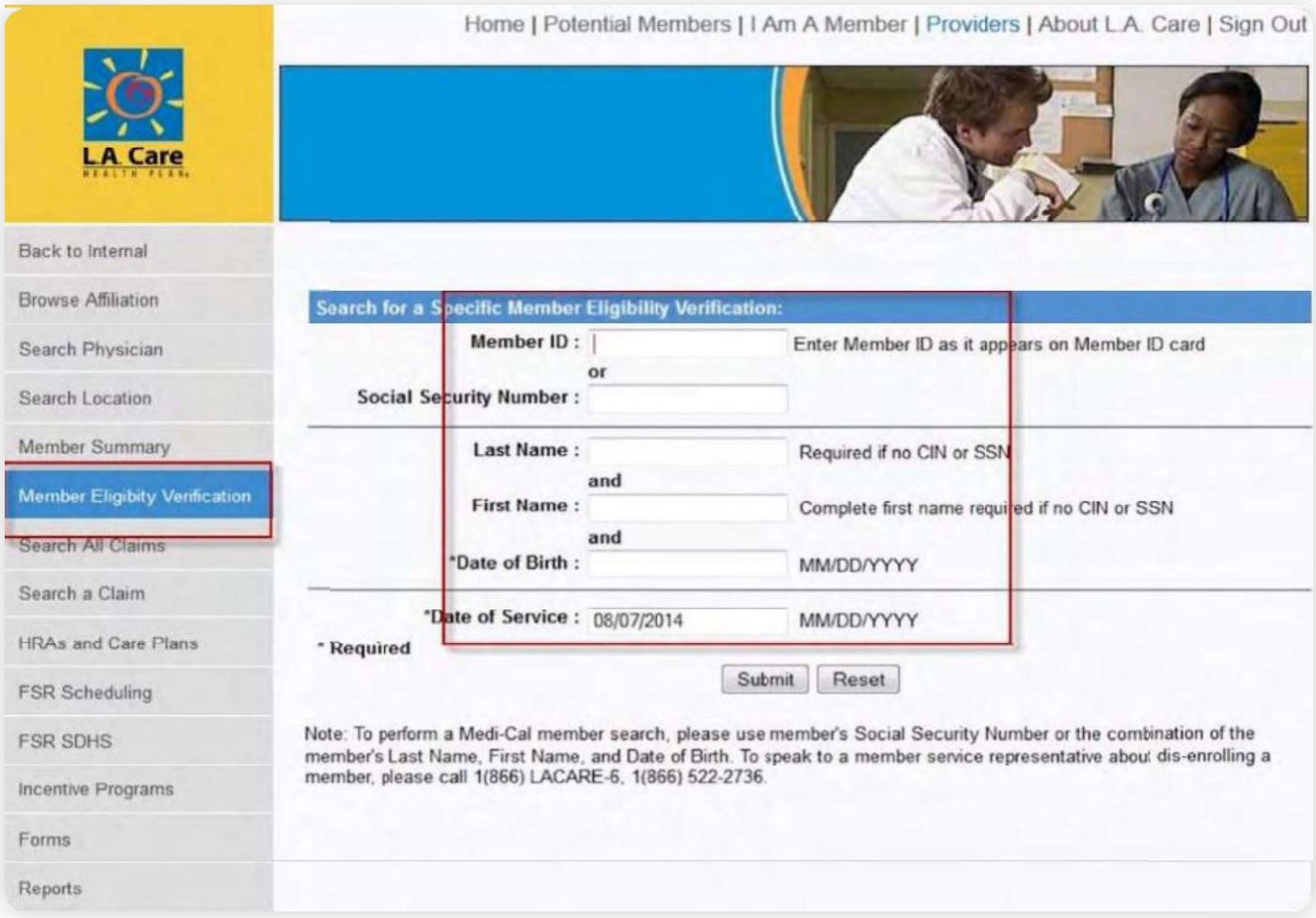
L.A. Care maintains a network of contracted hospitals and ancillary providers. Please contact your PPG/ MSO for the most recent list to be utilized for services provided to L.A. Care Direct members.

Checking Member Eligibility

A. Log on to the Provider Portal then select "Member Eligibility Verification."

B. Please fill out all fields with as much information as possible to get the best results. Click "submit" when finished. See Figure 1.

Figure 1.



Provider Portal: Registering a New Provider

All contracted physicians and specialist may self-register at http://www.lacare.org/providers/provider-sign-in/provider-registration.

All information marked with an asterisk is required in order for your request to be processed. See Figure 2.

Figure 2.

All other medical and administrative staff have to submit a request for registration for the Provider Portal. This request can be submitted via email to providerrelations@lacare.org or by phone at 1-213-694-1250 x 4719. The required information that needs to be specified is listed below:

- Name of organization (as listed in the contract)
- Organization address
- Full name of person(s) that need access
- Job title
- Phone number
- Email address
- Purpose/reason why access is needed

Please note all Provider Portal registration requests will be processed within 3 - 5 business days.

Once you receive access to the Provider Portal you will be notified via email to confirm your registration. You will have 24 hours to activate your account with the link provided to you by email. If you do not activate your account within the 24-hour period you will have to contact the Provider Relations department at PPO@lacare.org or by phone at 1-213-694-1250 x5200 to receive a new activation email for your account.

Seniors and Persons with Disabilities

Under federal and state law, medical care providers must provide individuals with disabilities:

- Full and equal access to their health care services and facilities
- Reasonable modifications to policies, practices, and procedures when necessary to make health care services accessible and,
- Effective communication, including auxiliary aids and services, such as the provision of sign language interpreters or written materials in alternative formats.

Physical Access

Providers must make their facilities, as well as their medical equipment and exam rooms accessible. The law requires the development and maintenance of accessible paths of travel to elevators, ramps, doors that open easily, reachable light switches, accessible bathrooms, accessible parking and signage that can assist individuals who are blind or have low vision.

Additionally, health care providers must provide accessible equipment, such as exam tables, diagnostic equipment and the use of a lift or trained staff who can ensure equal access to medical testing.

Reasonable Modifications

The Americans with Disabilities Act (ADA) provides protection from discrimination for people with all types of disabilities, including people with physical, cognitive, communication and mental health disabilities. Health care providers must make reasonable modifications in policies, practices and procedures when necessary to avoid discrimination on the basis of disability, unless the provider can demonstrate that making the modification would fundamentally alter the nature of the service, program or activity.

Examples of reasonable modifications health care providers may need to make for individuals with disabilities are:

- Spend additional time explaining individualized member care plans to ensure understanding
- Scheduling an appointment to accommodate a member with an anxiety disorder who has difficulty waiting in a crowded waiting room
- Allowing members to be accompanied by service dogs

Note: A health care provider cannot require individuals who are visually impaired or hard of hearing to bring someone with them to interpret or facilitate communication. Health care providers cannot charge members for providing any form of interpreter services.

Procedures for Providing Accommodations

Health care providers must:

- Ensure that individuals are informed of their right to request accommodations
- Provide individuals with information about the process for requesting accommodations
- Provide individuals with information about filing complaints about accommodations with L.A. Care if the provider is in the L.A. Care network, and filing complaints with other entities that oversee disability access laws in the health care context.

Health Assessments and Provider Toolkits

Initial Health Assessments

Primary Care Providers (PCP) are responsible for conducting a health assessment screening. All new members must have an initial health assessment (IHA) within:

- Medi-Cal members - 120 calendar days from the date of enrollment with L.A. Care. L.A. Care does not mandate utilization of a standardized form for the IHA. L.A Care does require the documentation of specific elements of the assessment. L.A. Care does provide samples of Well Child Assessment forms. A full description of the IHA process is available in the L.A. Care Provider Manual. Copies of the assessment forms are available at: **http://www.lacare.org/providers/provider-resources/provider-faqs/well-child-assessment-forms**.

Staying Healthy Assessments

For Medi-Cal enrollees, L.A. Care requires the completion of the Staying Healthy Assessments to be administered during the IHA and periodically thereafter as the patient enters a new age category. Forms are located at: **http://www.lacare.org/providers/provider-resources/staying-healthy-forms**.

Provider Toolkits

L.A Care maintains accessible toolkits and resources to assist providers in managing the care of our members. Currently toolkits include:

- Appropriate Use of Antibiotics
- Asthma
- Cardiovascular Care
- Childhood and Adolescent Wellness Flyers
- Chlamydia
- COPD
- Diabetes and Cardiovascular Care
- Obesity Toolkit for Adult and Children
- Pre/Post Bariatric Surgery Toolkit
- Perinatal Care
- Tobacco Control and Cessation
- Better Communication, Better Care: A Provider Toolkit for Serving Diverse Populations
- Behavior Health Provider Toolkit
- Behavioral Health Toolkit for PCPs
- Depression Provider Toolkit

The medical and mental health toolkits are available at **http://www.lacare.org/providers/provider-resources/provider-tool-kits**.

The CHDP program provides health assessments for the early detection and prevention of disease and disabilities for low-income children and youth.

CHDP health assessments screenings should consist of the following:

- health history
- physical examination
- developmental assessment
- nutritional assessment
- dental assessment
- vision and hearing tests
- a tuberculin test
- laboratory tests
- immunizations
- health education/anticipatory guidance
- referrals for any needed diagnosis and treatment

Early and Periodic Screening, Diagnostic and Treatment (EPSDT)

PCPs are required to follow-up with the components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal eligible children and youth.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) are a Medi-Cal benefit for individuals under the age of 21 who have full-scope Medi-Cal eligibility. This benefit allows for periodic screenings to determine health care needs. Based upon the identified health care need and diagnosis; treatment services are provided. EPSDT services include all services covered by Medi-Cal. A beneficiary under the age of 21 may receive additional medically necessary services.

EPSDT Screening Services

Screening services provided at intervals that meet standards of medical and dental practice, and at such other medically necessary intervals to determine the existence of physical or mental illnesses or conditions. Screening services must at a minimum include:

- a comprehensive health and developmental history (including assessment of both physical and mental health development)
- a comprehensive physical exam
- appropriate immunizations
- laboratory tests (including blood lead level taking into account age and risk factors)
- health education (including anticipatory guidance)

EPSDT Diagnostic Services

EPSDT covers medically necessary diagnostic services. When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnosis without delay.

ESPDT Treatment Services

Mental Health and Substance Use Services:

- Treatment for mental health and substance use issues and conditions is available under a number of Medi-Cal service categories, including hospital and clinic services, physician services, and services provided by a licensed professional such as a psychologist.

Medically Necessary Personal Care Services

- Are furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility, or institution for mental disease, that are:
  - (A) authorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State), otherwise authorized for the individual in accordance with a service plan approved by the State
  - (B) provided by an individual who is qualified to provide such services and is not a member of the individual's family
  - (C) furnished in a home or in another location

Oral Health and Dental Services:

- Dental care needed for relief of pain, infection and maintenance of dental health (provided as early an age as necessary).
- Emergency, preventive, and therapeutic services for dental disease that, if left untreated, may become acute dental problems or cause irreversible damage to the teeth or supporting structures.
- Medi-Cal Dental Care and Treatment Services are a carved out benefit for Medi-Cal members through the Medi-Cal Denti-Cal Program. Primary Care Providers are expected to perform dental screenings on all Medi-Cal members as part of the IHA, periodic, and other preventive health care visits and provide referrals to the Medi-Cal Denti-Cal Program for treatment. For children, Denti-Cal uses the periodicity schedule recommended by American Academy of Pediatric Dentistry (AAPD). Also some Dental benefits for adults 21 and older have been recently restored. To find a dentist, Medi-Cal members should be advised to call Denti-Cal at 1-800-322-6384 or visit **http://www.denti-cal.ca.gov**.

Vision and Hearing Services

- EPSDT requires that vision services be provided at intervals that meet reasonable standards as determined in consultation with medical experts, and at other intervals as medically necessary to determine the existence of a suspected illness or condition.
- At a minimum, vision services must include diagnosis and treatment for defects in vision, including eyeglasses.
- Glasses to replace those that are lost, broken, or stolen also must be covered.
- Medi-Cal vision benefits are covered by L.A. Care.
- L.A. Care has contracted with Vision Service Plan (VSP) to coordinate Medi-Cal vision care and lenses.
- To find out more about eye exams or vision care coverage for Medi-Cal members, call VSP at 1-800-877-7195 [TTY/TDD 1-800-428-4833].
- To find out more about eye exams or vision care coverage, you can also call L.A. Care Member Services at the toll free number 1-888-839-9909 [TTY/TDD 1-866-522-2731].

- EPSDT requires that hearing services be provided at intervals that meet reasonable standards as determined in consultation with medical experts, and at other intervals as medically necessary to determine the existence of a suspected illness or condition.
- Hearing services must include, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids.

Vaccines for Children (VFC)

The Vaccines for Children Program, established by an act of Congress in 1993, helps families by providing free vaccines to doctors who serve eligible children 0 through 18 years of age. The VFC program is administered at the national level by the United States Centers for Disease Control and Prevention (CDC) through the National Center for Immunization and Respiratory Diseases. The CDC contracts with vaccine manufacturers to buy vaccines at reduced rates. Enrolled VFC providers are able to order vaccine through their state VFC program and receive routine vaccines at no cost. This allows routine immunizations to eligible children without high out-of-pocket costs.

Appropriate documentation shall be entered in the member's medical record. It should indicate all attempts to provide immunizations. A receipt of vaccines or proof of prior immunizations; or proof of voluntary refusal of vaccines in the form of a signed statements by the member (if an emancipated minor) or the parent(s), or guardian of the member, shall be entered in the member's medical record. Please contact your PPG or MSO for further details.

The Vaccines for Children (VFC) Program is managed by the California Department of Public Health, Immunization Branch. A full description of the program and potential conditions is located at:

- **https://www.cdph.ca.gov/programs/immunize/Pages/HealthProfessionals.aspx**
- **http://eziz.org/vfc/overview/**

California Children Services (CCS)

CCS is a statewide program that treats children under the age of 21 with certain physical limitations and chronic health conditions or diseases. CCS can authorize and pay for specific medical services and equipment provided by CCS-approved specialists. The California Department of Health Services manages the CCS program. Providers are required to refer children with certain physical limitations and chronic health conditions or diseases to a CCS paneled provider or CCS Specialty Care Center for care. A full description of the program and potential CCS conditions is located at:

- **http://publichealth.lacounty.gov/cms**
- **http://www.lacare.org/providers/provider-resources/provider-faqs/ccs**

Services for the Developmentally Disabled

The term developmental disability refers to a severe and chronic disability that is attributable to a mental or physical impairment that begins before an individual reaches adulthood. These disabilities include mental retardation, cerebral palsy, epilepsy, autism, and disabling conditions closely related to mental retardation or requiring similar treatment.

For an individual to be assessed in California as having a developmental disability, the disability must begin before the individual's 18th birthday, be expected to continue indefinitely and present a substantial disability. For additional information, please visit the L.A. Care website at: **http://www.lacare.org/dds-0**

Early Intervention/Early Start

A child with or at risk of developmental delay or disability can receive an "Early Start" in the State of California. Teams of service coordinators, health care providers, early intervention specialists, therapists, and parent resource specialists can evaluate and assess an infant or toddler. They can also provide appropriate early intervention services to children eligible for California Early Start. For more information, please refer to the section below; "Primary Care Responsibilities for Care Coordination with Linked and Carved out Services."

Eligibility Criteria

Infants and toddlers from birth to 36 months may be eligible for Early Intervention services through documented evaluation and assessment if they meet one of the criteria listed below:

- Have a developmental delay in either cognitive, communication, social or emotional, adaptive, or physical and motor development including vision and hearing
- Have established risk conditions of known etiology, with a high probability resulting in delayed development
- Are at high risk of having a substantial developmental disability due to a combination of risk factors

For additional information on Early Intervention and Early Start, please see L.A. Care's website at: **http://www.lacare.org/dds-0**

Primary Care Responsibilities for Care Coordination with Linked and Carved out Services

PCPs are responsible for Coordination of Care for Linked and Carved out Services (i.e. CCS, DDS, Regional Centers, etc.).

Care Managers at L.A. Care or the PPG/MSO are available to assist members, who may need or who are receiving services from out of plan providers and/or programs. This service is available to ensure coordinated service delivery and effective joint case management. The coordination of care and services remains the responsibility of each member's PCP. PPG's and the member's PCP will monitor the following:

- Member referral to and/or utilization of special programs and services
- Member referral to and/or utilization of specialty care, including ensuring consultative notes and summaries are maintained in the medical home records
- Routine medical care, including providing the necessary preventive medical care and services
- Provision of Initial Health Assessments including the Staying Healthy Assessment (SHA)

PPGs/MSOs and PCPs are encouraged to make referrals to local health departments, mental health programs and regional centers.

Out-of-Plan Case Management and Coordination of Care for Linked and Carved out Services

L.A. Care maintains procedures to identify individuals, who may need or who are receiving services from out of plan providers and/or programs. These procedures are established in order to ensure coordinated service delivery and efficient and effective joint case management.

Medical Record Documentation

L.A. Care requires physician offices to maintain a certain level of medical record documentation. L.A. Care will assess records using the DHCS Medical Record Review Guidelines during the Facility Site Review process. A copy of the guidelines are available at: **http://www.lacare.org/providers/provider-resources/provider-faqs/well-child-assessment-forms**.

Behavioral Health

Beacon Health Options is L.A. Care's delegated vendor for non-specialty mental health services. All services listed below are provided to our members:

- Individual, and group mental health evaluation and treatment (psychotherapy)
- Psychological testing when clinically indicated to evaluate a mental health condition
- Outpatient services for the purposes of monitoring medication and treatment
- Outpatient laboratory, medications, supplies and supplements
- Psychiatric consultation
- For non-specialty mental health services, please contact:
  - Beacon Health Options
  - Phone Line: 1-877-344-2850

County Specialty Mental Health

There are no changes to County Specialty Mental Health services provided by Los Angeles County Department of Mental Health (DMH) or Substance Use Disorder Treatment by the Department of Public Health (DPH).

- For Specialty Mental Health services, please contact:
  - L.A. County Department of Mental Health (DMH)
  - Phone Line: 1-855-854-7771
- For Specialty Substance Use Disorder treatment, please contact:
  - L.A. County Department of Public Health (DPH)
  - Phone Line: 1-800-564-6600

L.A. Care's Behavioral Health Department

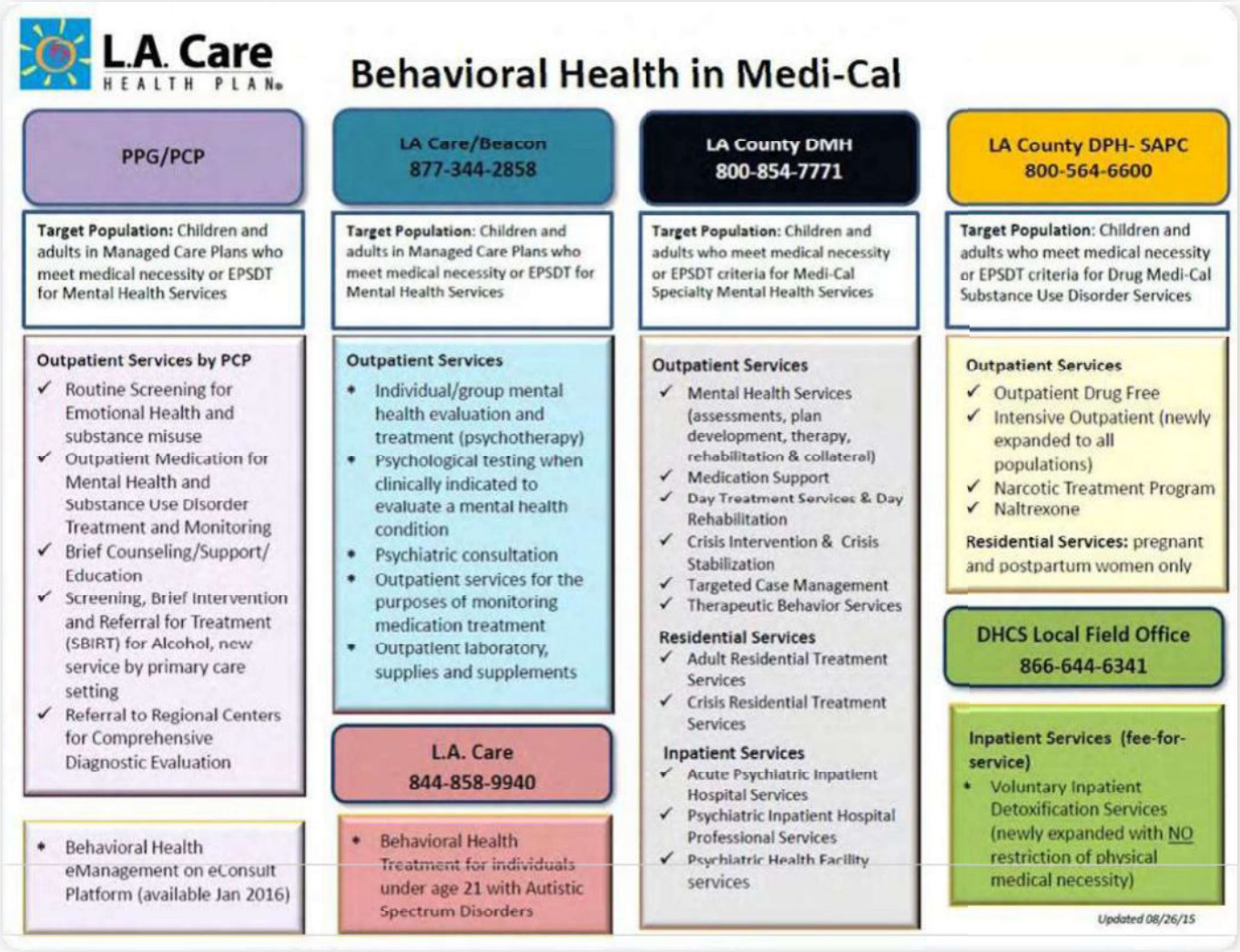
L.A. Care's Behavioral Health Department has licensed behavioral health staff dedicated to supporting you with the services listed below:

- Resolve behavioral health service access issues
- Ensure appropriate clinical transfer in behavioral health system of care
- Assist with service system coordination provided by the Beacon network
- Facilitate Care Coordination between Care Management and PPG Case Managers for behavioral health services
- Educate and train providers and the community
- Support members with behavioral health grievances, appeals and advocacy

This service is available Monday to Friday from 8 a.m. to 5 p.m. You can reach us by phone at 1-844-858-9940 or via email at **behavioralhealth@lacare.org**. Please note that protected health information (PHI) must be sent secured.

The following diagram illustrates services and correlating contact information for L.A. Care's Behavioral Health Medi-Cal program. See figure 3.

Figure 3.


L.A. Care HEALTH PLAN
Behavioral Health in Medi-Cal
PPG/PCP
Target Population: Children and adults in Managed Care Plans who meet medical necessity or EPSDT for Mental Health Services
Outpatient Services by PCP
✓ Routine Screening for Emotional Health and substance misuse
✓ Outpatient Medication for Mental Health and Substance Use Disorder Treatment and Monitoring
✓ Brief Counseling/Support/ Education
✓ Screening, Brief Intervention and Referral for Treatment (SBIRT) for Alcohol, new service by primary care setting
✓ Referral to Regional Centers for Comprehensive Diagnostic Evaluation
• Behavioral Health eManagement on eConsult Platform (available Jan 2016)
LA Care/Beacon
877-344-2858
Target Population: Children and adults in Managed Care Plans who meet medical necessity or EPSDT for Mental Health Services
Outpatient Services
• Individual/group mental health evaluation and treatment (psychotherapy)
• Psychological testing when clinically indicated to evaluate a mental health condition
• Psychiatric consultation
• Outpatient services for the purposes of monitoring medication treatment
• Outpatient laboratory, supplies and supplements
L.A. Care
844-858-9940
• Behavioral Health Treatment for individuals under age 21 with Autistic Spectrum Disorders
LA County DMH
800-854-7771
Target Population: Children and adults who meet medical necessity or EPSDT criteria for Medi-Cal Specialty Mental Health Services
Outpatient Services
✓ Mental Health Services (assessments, plan development, therapy, rehabilitation & collateral)
✓ Medication Support
✓ Day Treatment Services & Day Rehabilitation
✓ Crisis Intervention & Crisis Stabilization
✓ Targeted Case Management
✓ Therapeutic Behavior Services
Residential Services
✓ Adult Residential Treatment Services
✓ Crisis Residential Treatment Services
Inpatient Services
✓ Acute Psychiatric Inpatient Hospital Services
✓ Psychiatric Inpatient Hospital Professional Services
✓ Psychiatric Health Facility services
LA County DPH- SAPC
800-564-6600
Target Population: Children and adults who meet medical necessity or EPSDT criteria for Drug Medi-Cal Substance Use Disorder Services
Outpatient Services
✓ Outpatient Drug Free
✓ Intensive Outpatient (newly expanded to all populations)
✓ Narcotic Treatment Program
✓ Naltrexone
Residential Services: pregnant and postpartum women only
DHCS Local Field Office
866-644-6341
Inpatient Services (fee-for-service)
• Voluntary Inpatient Detoxification Services (newly expanded with NO restriction of physical medical necessity)
Updated 08/26/15

Case Management

L.A. Care has a Case Management department (also known as Care Management) with specially trained staff to help members with complex care needs or members at high risk for adverse outcomes. Examples of members with complex needs may include:

- Serious acute or chronic health condition (trauma, new cancer diagnosis)
- multiple uncontrolled health conditions
- complicated social issues (no social support)

Please refer members with complex needs to L.A. Care through the following ways:

- Complete the Care Management Referral Form which is available on the L.A. Care Provider Portal
- Simply call the Care Management department during regular business hours at: 1-844-200-0104

We will work with our members to develop an Individualized Care Plan (ICP) and provide you with updates to the plan after holding an Interdisciplinary Care Team (ICT) meeting with participants most appropriate to address individualized needs.

Managed Long-Term Services and Supports (MLTSS)

MLTSS is a wide range of services that provide support to seniors and individuals with disabilities so that they can remain living safely at home. Services available to L.A. Care members under MLTSS include:

- **In Home Supportive Services (IHSS):** Provides in home care for seniors and people with disabilities. Eligible members can hire anyone they wish to help them with their daily needs. This includes assistance with home chores, personal care assistance, basic medical needs, getting to provider appointments and providing supervision for people with dementia or other mental impairments.
- **Multipurpose Senior Services Program (MSSP):** Provides intensive care coordination services in the home for seniors age 65 and older. An MSSP nurse and social worker team will provide eligible members with a full assessment of their health and social support needs. Additionally the MSSP team will identify, arrange and provide help with accessing resources, monitor the member's wellbeing, and purchase other needed services that may not be available through L.A. Care or other community based programs.
- **Community Based Adult Services (CBAS):** Provides professional nursing services, physical, occupational and speech therapies, socialization, mental health services, therapeutic activities, social services, nutrition and nutritional counseling for people ages 18 and older. CBAS is a day program formerly known as adult day health care center.
- **Long Term Care (LTC):** Provides continuous skilled nursing care to eligible members with physical or mental conditions in a nursing home. The Medi-Cal LTC nursing facility benefit includes room and board and other medically necessary services.

L.A. Care members receiving MLTSS often have complex needs. They may be diagnosed with multiple chronic conditions (functional and cognitive) or may lack social, educational, and economic support. The MLTSS department can help support your patient's access to needed care by:

- Determining if they are IHSS, CBAS, MSSP and LTC eligible
- Coordinating and navigating IHSS, MSSP and CBAS assessment
- Resolving IHSS, MSSP, CBAS and LTC related issues and navigating the grievance and appeals process
- Applying for IHSS and MSSP services
- Coordinating requests for expedited assessments
- Providing temporary services to fill in coordination of care gaps
- Following up with IHSS, MSSP, CBAS, and LTC services to ensure services are being provided
- Referring to local CBAS centers and MSSP sites
- Accessing community based organizations for non-plan services

To find MLTSS Referral forms, go to the L.A. Care website: **http://www.lacare.org/providers/provider-resources/provider-forms**

MLTSS Contact Information

For Managed Long Term Services and Supports questions:

MLTSS Phone Line: 1-855-427-1223

MLTSS Fax Line: 1-213-438-4877

MLTSS Email: mltss@lacare.org

L.A. Care Website: **www.lacare.org**

Federal and State Statutes

Federal Statutes

The Centers for Medicare & Medicaid Services(CMS), is part of the Department of Health and Human Services (DHHS). They administer Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and parts of the Patient Protection and the Affordable Care Act (ACA).

The link below provides access to proposed and existing statutes and regulations relevant to CMS.

https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Guidance.html

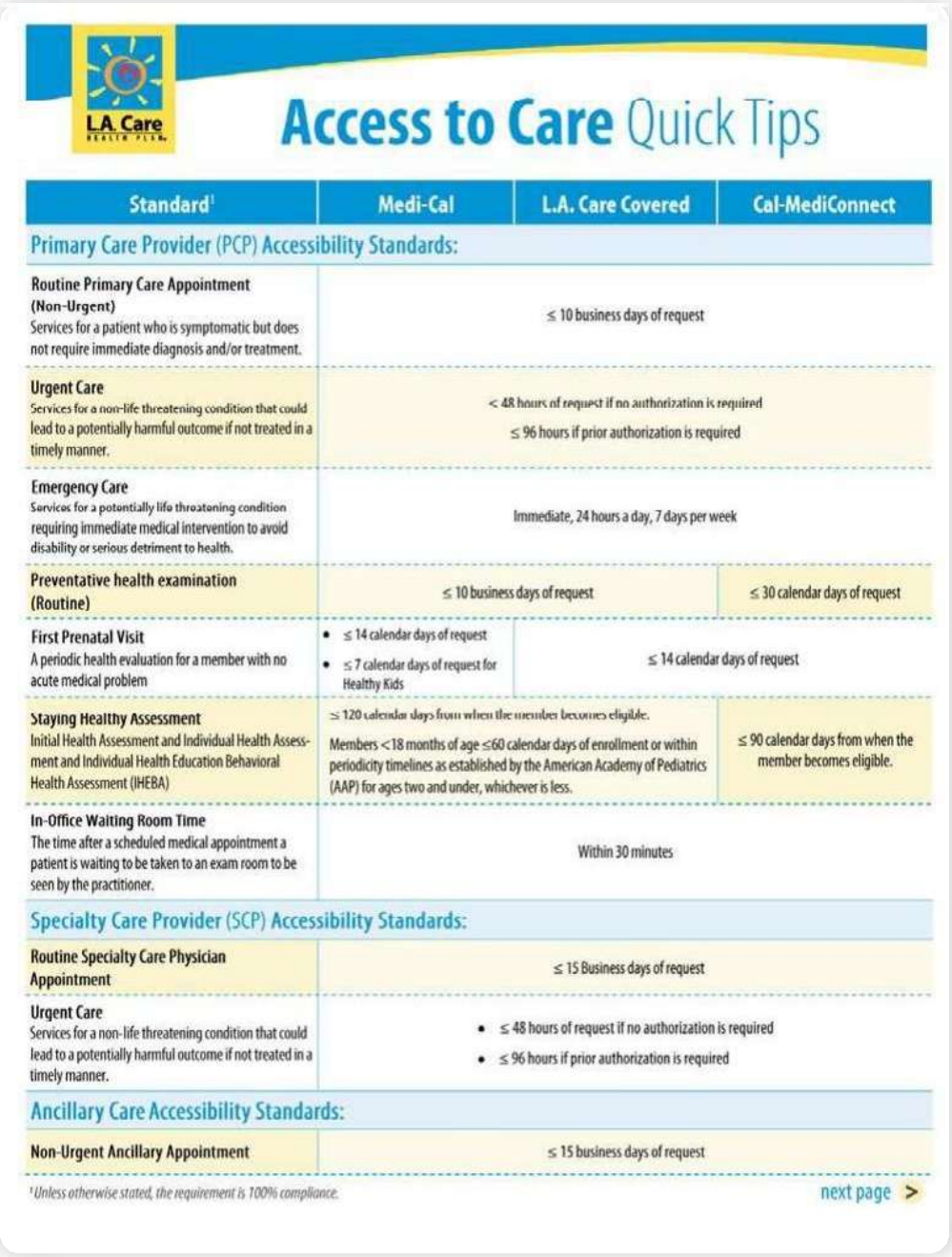
State Statutes

The Department of Health Care Services (DHCS) was created and is directly governed by California statutes passed by the California Legislature. These statutes grant DHCS the authority to establish programs and adopt regulations.

The link below provides access to proposed and existing statutes and regulations relevant to the DHCS.

http://www.dhcs.ca.gov/formsandpubs/laws/Pages/LawsandRegulations.aspx

L.A. Care requires primary care physicians, behavioral health providers, specialists and ancillary providers to be compliant with access and availability standards. The standards are provided below.



LA Care HEALTH PLAN

Access to Care Quick Tips

Standard[1]	Medi-Cal	L.A. Care Covered	Cal-MediConnect
Primary Care Provider (PCP) Accessibility Standards:			
Routine Primary Care Appointment (Non-Urgent) Services for a patient who is symptomatic but does not require immediate diagnosis and/or treatment.	≤ 10 business days of request		
Urgent Care Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.	< 48 hours of request if no authorization is required ≤ 96 hours if prior authorization is required		
Emergency Care Services for a potentially life threatening condition requiring immediate medical intervention to avoid disability or serious detriment to health.	Immediate, 24 hours a day, 7 days per week		
Preventative health examination (Routine)	≤ 10 business days of request		≤ 30 calendar days of request
First Prenatal Visit A periodic health evaluation for a member with no acute medical problem	• ≤ 14 calendar days of request • ≤ 7 calendar days of request for Healthy Kids	≤ 14 calendar days of request	
Staying Healthy Assessment Initial Health Assessment and Individual Health Assessment and Individual Health Education Behavioral Health Assessment (IHEBA)	≤ 120 calendar days from when the member becomes eligible. Members < 18 months of age ≤60 calendar days of enrollment or within periodicity timelines as established by the American Academy of Pediatrics (AAP) for ages two and under, whichever is less.		≤ 90 calendar days from when the member becomes eligible.
In-Office Waiting Room Time The time after a scheduled medical appointment a patient is waiting to be taken to an exam room to be seen by the practitioner.	Within 30 minutes		
Specialty Care Provider (SCP) Accessibility Standards:			
Routine Specialty Care Physician Appointment	≤ 15 Business days of request		
Urgent Care Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.	• ≤ 48 hours of request if no authorization is required • ≤ 96 hours if prior authorization is required		
Ancillary Care Accessibility Standards:			
Non-Urgent Ancillary Appointment	≤ 15 business days of request		

[1] *Unless otherwise stated, the requirement is 100% compliance.*

next page >

Standard[1]	Medi-Cal	L.A. Care Covered	Cal-MediConnect
Behavioral Health Care Accessibility Standards:			
Routine Appointment (includes non-physician behavioral health providers)	≤ 10 business days of request		
Urgent Care Services for a non-life threatening condition that could lead to a potentially harmful outcome if not treated in a timely manner.	≤ 48 hours of request		
Life Threatening Emergency	Immediately		
Non-Life Threatening Emergency	≤ 6 hours of request		
Emergency Services	Immediate, 24 hours a day, 7 days per week		
After Hours Care Standards:			
After Hours Care Physicians (PCP, Behavioral Health Provider and Specialists, or covering physician) are required by contract to provide 24 hours a day, 7 days per week coverage to members. Physicians, or his/her on-call coverage or triage/screening clinician must return urgent calls to member, upon request within 30 minutes. *Clinical advice can only be provided by appropriately qualified staff, e.g., physician, physician assistant, nurse practitioner or RN.	• Automated systems must provide emergency 911 instructions; and • Automated system or live party (office or professional exchange service) answering the phone must offer a reasonable process to connect the caller to the PCP, Behavioral Health Provider, Specialist or covering practitioner, or offer a call-back from the PCP, Behavioral Health Provider, Specialist, covering practitioner or triage/screening clinician within 30 minutes If process does not enable the caller to contact the PCP, Behavioral Health Provider, Specialist or covering practitioner directly, the "live" party must have access to a practitioner or triage/screening clinician for both urgent and non-urgent calls.		
Call Return Time (Practitioner's Office) The maximum length of time for PCP, Behavioral Health Provider, Specialist offices, covering practitioner or triage/screening clinician to return a call after hours.	≤ 30 minutes *Clinical advice can only be provided by appropriately qualified staff, e.g., physician, physician assistant, nurse practitioner or RN.		
Practitioner Telephone Responsiveness:			
Speed of Telephone Answer (Practitioner's Office) The maximum length of time for practitioner office staff to answer the phone.	≤ 30 seconds		
Member Services Department Call Service Standards:			
Speed of Telephone Answer • The maximum length of time for Member Services Department staff to answer the telephone. • Call Abandonment Rate	• 90% of calls ≤ 30 seconds • NTE 5% in a calendar month		

[1] *Unless otherwise stated, the requirement is 100% compliance.*

1-866-LACARE6 (1-866-522-2736)
www.lacare.org

V. 10/5/2015

Members Rights and Responsibilities

L.A. Care Members have the right to the following:

- **Respectful and courteous treatment:** Members have the right to be treated with respect, dignity and courtesy by their provider and staff. Members have the right to be free from retaliation or force of any kind when making decisions about their care.
- **Privacy and confidentiality:** Members have the right to have their medical records kept confidential. Provider offices must implement and maintain procedures that protect against disclosure of confidential patient information to unauthorized persons. Members also have the right to receive a copy of and request corrections to their medical records. Physicians must abide by California State minor consent laws. Members have the right to be counseled on their rights to confidentiality and members consent is required prior to the release of confidential information, unless such consent is not required.
- **Choice and involvement in their care:** Members have the right to receive information about their health plan, services, and providers. Members have the right to choose their Primary Care Provider (PCP) from L.A. Care's provider directory. Members also have the right to obtain appointments within access standards. Members have the right to talk with their provider about any care provided or recommended. Members have the right to discuss all treatment options, and participate in making decisions about their care. Members have the right to a second opinion. Members have the right to speak candidly to their provider about appropriate or medically necessary treatment options for their condition. Members have the right to deny treatment. Members have the right to decide in advance how they want to be cared for in case of a life-threatening illness or injury. Members also have the right to assist with the formulation of their advanced directives. Written policies and procedures respecting advanced directives shall be developed in accordance.
- **Voice concerns:** Members have the right to grieve about L.A. Care and/or its affiliated providers. They also have the right to receive care without fear of losing their benefits. L.A. Care will help members with the grievance process. If members don't agree with a decision, they have the right to appeal. Members have the right to disenroll from their health plan whenever they want. As a Medi-Cal member, they have the right to request a State Fair Hearing, including information on the circumstances under which an expedited fair hearing is possible.
- **Service outside of L.A. Care's provider network:** Members have the right to receive emergency or urgent services as well as family planning and sexually transmitted disease services outside of their health plan's network. Members also have access to Federally Qualified Health Centers and Indian Health Services Facilities.
- **Service and information:** Members have the right to request an interpreter at no charge and not use a family member or a friend to translate for them. Members have the right to access the Member Handbook and other information in another language or format, including; braille, large size print, and audio format upon request.
- **Know their rights:** Members have the right to receive information about their rights and responsibilities. Members have the right to make recommendations about their rights and responsibilities. Members have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.

As a member of L.A. Care members have the responsibility to:

- **Act courteously and respectfully:** Members are responsible for treating providers and staff with courtesy and respect. Members are responsible for being on time for their visits or calling your office at least 24 hours before the visit to cancel or reschedule.
- **Give up-to-date, accurate and complete information:** Members are responsible for giving correct information and as much information as they can to all of their providers and L.A. Care. Members are responsible for getting regular check-ups and telling their provider about health problems before they become serious.
- **Members should follow their provider's advice and take part in their care:** Members are responsible for talking about their health care needs with their provider, developing and agreeing on goals, doing their best to understand their health problems following the treatment plans and instructions you both agree on.
- **Use the Emergency Room only in an emergency:** Members are responsible for using the emergency room in case of an emergency or as directed by their provider.
- **Report wrong doing:** Members are responsible for reporting health care fraud or wrong doing to L.A. Care. Members can do this without giving their name by calling the L.A. Care Fraud and Abuse Hotline toll-free at 1-800-400-4889.

To access the L.A. Care Member Rights section on the website go to **http://www.lacare.org/members/member-protection/member-rights**.

Cultural and Linguistic Services

L.A. Care provides an array of cultural and linguistic services and resources to assist you in delivering effective patient-centered care. The following is a quick guide to help you and your staff understand the state and federal regulatory requirements that guide cultural and linguistic services to ensure compliance.

Bilingual Staff

Effective communication though qualified interpreters improves quality of care, increases member satisfaction and minimizes the risk of liability and malpractice lawsuits. L.A. Care offers no cost qualified interpreting services to you and your members in an effort to discourage the use of bilingual staff as interpreters. If a member of your staff is bilingual and utilizes the second language to interact with members, it is important they are qualified and proficient in English and the other language with proper training and education.

Please maintain the following documentation for your qualified bilingual staff:

- Certification for medical interpreters
- Number of years of service employed as an interpreter (e.g. resume)
- Certificate of completion interpreter training program
- Bilingual skills self-assessment

Bilingual Language Skills Self-Assessment Tool

The self-assessment tool is a resource to assist you in identifying language skills and resources existing in your office. It can be used to document bilingual skills of your staff before the professional assessment. The self-assessment tool is included in Section 1 of "What you need to know" in the Provider Toolkit. The assessment should be conducted annually for office staff and every three years for physicians.

- To order the toolkits go to **https://external.lacare.org/HealtheForm/**
- To download the toolkits go to **http://www.lacare.org/providers/provider-resources/provider-tool-kits**

Interpreting Services

Qualified interpreting services are essential to communicating effectively with limited English proficient members. L.A. Care's face-to-face and telephonic interpreting services are available to you and your staff at no charge. Interpreting services also include American Sign Language (ASL). The following information describes how to access these services:

- Face-to-face Interpreting Services
  - Call 1-888-839-9909 to request an interpreter for medical appointments.
- Telephonic Interpreting Services
  - Call 1-888-930-3031 to be connected with an interpreter over the phone immediately.
- California Relay Services
  - Call 711 to communicate with the deaf and hard of hearing members over the phone.

Key Things to Remember

- Inform members of the availability of no-cost 24/7 interpreting services including ASL.
- Document the member's preferred language in the medical chart.
- Discourage use of friends, family members and minors as interpreters.
- Document member's request/refusal of interpreting services in the medical chart after no-cost interpreting services are offered to them.

Language Poster

The language poster is an effective way to let your staff and members know about availability of no cost interpreting services and how to access the services from L.A. Care. The poster is translated into 14 languages and should be posted at the key points of contact such as front office and exam rooms.

To order the posters, go to **https://external.lacare.org/HealtheForm/**

Telephonic Interpreting Card

Keep the card available for easy access to no cost telephonic interpreters.

To order the telephonic card, go to **https://external.lacare.org/HealtheForm/**

Cultural and Linguistic Training

The following workshops are a rapid way to learn how to deliver culturally and linguistically appropriate care to diverse member populations. The below instructor-led classroom or Learning Management System (LMS) trainings are available at no cost for your convenience:

- Interpreting Services
- Cultural Competency
- Disability Awareness

To schedule classroom training sessions at your facility, contact **CLStrainings@lacare.org**

To access online LMS, go to **https://lacareuniversity.torchlms.com**

Cultural and Linguistic Provider Toolkit

The provider toolkit is a comprehensive guide to culturally and linguistically appropriate services. It is organized in five sections which contain helpful information and tools that can be reproduced as needed.

- To order the toolkits, go to **https://external.lacare.org/HealtheForm/**.
- To download the toolkits, go to **http://www.lacare.org/providers/provider-resources/provider-tool-kits**.

Online Resource Directory

To refer the members to cultural and linguistic community services, go to **http://www.healthycity.org/**.

The following are suggested best practices. The information consists of useful reminders and tips providers and medical office staff can utilize to enhance a positive customer service experience.

Build rapport with the member

- Address members by their last name if the member's preference of greeting is not clear
- Focus your attention on members when addressing them
- Learn basic words in your member's primary language, like "hello" or "thank you"
- Explain the different roles performed by office staff

Make sure members know your role

- Take a few moments to prepare a handout that explains office hours, how to contact the office when it is closed and how the provider coordinates specialty care
- Have instructions professionally translated and available in the common language(s) spoken by your member panel
- It is not necessary to raise the volume of your voice if the issue is language comprehension and not hearing

Keep members' expectations realistic

- Inform members of delays or extended wait times

Work to build members trust

- Inform members of office procedures, such as when they can expect a call with lab results, how follow-up appointments are scheduled and routine wait times

Determine if the member needs an interpreter for the visit

- Document the member's preferred language in the member chart
- Have an interpreter access plan. Use of interpreters with a medical background is strongly encouraged, rather than family, minors or friends of the member
- Assess your bilingual clinical staff for interpreter abilities

Give members the information they need

- Have health education materials in languages that reflect your membership
- Offer handouts such as immunization guidelines for adults and children, screening guidelines and culturally relevant dietary guidelines for diabetes or weight loss

Make sure members know what to do

- Review any follow-up procedures with the member before they leave your office
- Verify call back numbers, the locations for follow-up services such as labs, X-ray or screening tests and whether or not a follow-up appointment is necessary

Develop pre-printed simple handouts of frequently used instructions and translate the handouts into the common language(s) spoken by your membership

Styles of Speech

People vary greatly in the length of time between comments and responses. The speed of their speech and their willingness to interrupt may vary.

- Tolerate gaps between questions and answers; impatience can be seen as a sign of disrespect
- Listen to the volume and speed of the member's speech as well as the content. Modify your own speech to more closely match that of the member to make them more comfortable
- Rapid exchanges and even interruptions are a part of some conversational styles
- Do not be offended if a member interrupts you
- Stay aware of your interruption patterns, especially if the member is older than you are

Eye Contact

The way people interpret various types of eye contact is tied to cultural background.

- Look people directly in the eyes to demonstrate communication engagement
- For other cultures, direct eye contact is considered rude or disrespectful. Never force a member to make eye contact with you.
- If a member seems uncomfortable with direct eye contact, try sitting next to them instead of across from them

Body Language

- Follow the member's lead on physical distance and contact
- Stay sensitive to those who do not feel comfortable
- Gestures can have different meanings
- Be conservative in your own use of gestures and body language
- Do not interpret member's feelings or level of pain solely from facial expressions

Gently Guide Member Conversation

English language predisposes us to a direct communication style however, other languages and cultures differ.

- Non English speaking members or individuals from diverse cultural backgrounds may be less likely to ask questions

Facilitate member-centered communication

- Avoid questions that can be answered with "yes" or "no"
- Steer the member back to the topic by asking a question that clearly demonstrates that you are listening
- Some members can tell you more about their health through story telling than by answering direct questions

Thank you for taking this training. Please make sure to sign and attest that you have read and understood this information and provide a copy to your PPG or MSO. If you would like more information, please refer to the L.A. Care Provider Manual. If you have additional questions, please contact your PPG or MSO.

Produced by the L.A. Care Provider Network Operations department.

ST. VINCENT IPA
The Patient's Choice for Health Care

18000 Studebaker Rd. Suite 700
Cerritos, CA 90703
Phone (562) 860-8771
www.stvincentipa.com

Important Memorandum

To: St Vincent IPA Provider Network
From: Michael Gella, IPA Manager/ Administrator
Date: October 22, 2024
Re: Medi-Cal Programs

Dear Provider,

Please be advised, we have updated our Provider Manual to include information on the following Medi-Cal programs:

- Palliative Care
- California Children Services
- Behavioral Health Treatment
- Health Homes
- End of Life Services

Please take a moment to review and share with your staff. To access the most recent version of The St Vincent IPA Provider Manual please visit the provider portal:

https://stvincentipa.com/documents/

On behalf of the IPA, we thank you for continuing to provide excellent service to our members. Feel free to contact the Provider Relations department with any questions or concerns regarding this memo at (562) 860-8771 Ext.112.

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PALLIATIVE CARE (CARVE-OUT)

Palliative care consists of patient-and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. The provision of palliative care does not result in the elimination or reduction of any covered benefits or services under the MCP contracts and does not affect a member's eligibility to receive any services, including home health services, for which the member would have been eligible in the absence of receiving palliative care. Unlike hospice, palliative care does not require the member to have a life expectancy of six months or less, and palliative care may be provided concurrently with curative care. A member 21 years of age or older may not be concurrently enrolled in hospice care and palliative care. A member under 21 years of age may be eligible for palliative care and hospice services concurrently with curative care.

CALIFORNIA CHILDREN SEVICES

CCS is a state funded program for children up to 21 years, who are residents of California and meet other qualifications, with specific qualifying diseases/health problems (e.g., Chronic diseases, inherited metabolic disorders, malignancies, Multiple traumas, and NICU neonate). CCS will arrange for CCS paneled health care practitioner treatment for children with special healthcare needs. Lists are available online, per county, for staff familiarization of particular qualification types.

1). CCS Referral Policies and Procedures description includes:
Department staff members identify children with potentially CCS eligible conditions and arrange for their timely referral to the local or dependent CCS office. California Children's Services' (CCS) are carved out services for those services that are paid by CCS. The Provider Organization is responsible for portions of services that may not be covered by CCS.

2).Referral process includes:

- Provider Organization follows-up with CCS until a final outcome of the CCS deferral (approval or denial) from CCS is received
- Provider Organization provision of all medically necessary covered services until CCS eligibility is confirmed
- Provider Organization immediate referral of all potential or actual CCS cases to CCS, not to exceed one business day from date of identification
- The responsibility for making referrals to CCS and for follow up with CCS on the outcome of the referrals is clearly defined
- Provider Organization referral log maintenance of all CCS referrals, and monthly transmission to Medicaid, Anthem Blue Cross
- The responsibility for log maintenance and transmission to the Health Plan is clearly defined

3) CCS Process Evidence must include at least one of the following:

- List of contracted and/or non-contracted CCS paneled practitioners which the organization makes available to its practitioners/providers & UM staff

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- UMC Quarterly meeting minutes to include discussion of CCS data report
- CCS Referral logs submitted monthly to Anthem
- Claims sweeps for CCS eligible diagnoses

HEALTH HOMES (Carve-Out)

Medicaid health homes was created to coordinate the full range of physical health care services, behavioral health services, and community-based long term services and supports (LTSS) needed by members with chronic conditions.

MCP is responsible for providing the following six core HHP services to eligible MediCal members: comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services.

END OF LIFE SERVICES (Carve Out)

Terminally ill members, age 18 or older with the capacity to make medical decisions are permitted to request & receive prescriptions for aid-in-dying medications if certain conditions are met. Provision of these services by health care providers is voluntary and refusal to provide these services will not place any physician at risk for civil, criminal or professional penalties. End of Life Services include consultations and the prescription of an aid-in-dying drug. EOL services are a "carve out" for Medi-Cal Managed Care Health Plans (MCPs) and are covered by Medi-Cal FFS. Members are responsible for finding a Medi-Cal FFS Physician for all aspects of the EOL+benefit. Policy & Procedure describes: 1). During an unrelated visit with an MCP physician, a member may provide an oral request for EOL services. If the physician is also enrolled with the Department of Health Care Services (DHCS) as a Medi-Cal FFS provider, that physician may elect to become the member's attending physician as he or she proceeds through the steps in obtaining EOL services.
2). EOL services following the initial visit are no longer the responsibility of the MCP, and must be completed by a Medi-Cal FFS attending physician, or a Medi-Cal FFS consulting physician.
3). Alternatively, if the MCP physician is not a Medi-Cal FFS provider, the physician may document the oral request in his or her medical records as part of the visit. 4). MCP physician should advise the member that following the initial visit he or she must select a Medi-Cal FFS physician in order for all of the remaining requirements to be satisfied.

Evidence:

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Dear Office Admin,

The **Comprehensive Perinatal Services Program (CPSP)** is a Medi-Cal program that provides individualized perinatal services during pregnancy and 60 days following delivery by or under the personal supervision of physicians approved by CPSP. **All Medi-Cal members must be offered CPSP services**.

CPSP has uniquely divided authority between the Department of Health Care Services (DHCS) and the California Department of Public Health (CDPH). CDPH is responsible for CPSP provider enrollment and monitoring/oversight of the implementation of the CPSP Program.

The program emphasizes nutritional services, psychosocial support, health education and postpartum treatment and intervention.
Obstetrics/Gynecology specialist are responsible for assessing member needs and referring all pregnant members to a CPSP provider for the following:

- Community Prenatal Services
- Women, infants and Children Program (WIC)
- Substance abuse programs
- Prenatal education classes

If your office is interested in additional training, the link below offers virtual training courses for CPSP providers.
Link: http://publichealth.lacounty.gov/mch/cpsp/CPSPwebpages/cpsp_training.htm
Resources: https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx

Please note if the member declines CPSP services, please have the member sign the Acknowledgement Form stating they were offered services and declined (form attached). Once completed, please submit to me directly for record keeping purposes. **Member participation in CPSP is voluntary**.

SVIPA will be sending a monthly Member list at the beginning of the month, and we request that you please respond by the 15th of the month.
We ask that you please review the spreadsheet and fill-out columns: I – O (Questions in red font), and return to me.

If you should have any questions, please feel free to contact your Provider Relations Specialist @562-860-8771.

NEW PROVIDER ORIENTATION PACKET

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St Vincent IPA
New Provider Orientation Attestation

Provider Name: _____ **Contract Effective Date:** _____

Is the Provider(s) **PCP**, **SCP**, or **Ancillary**? (Circle one) **COUNTY:** _____

I acknowledge that our office has been oriented on the following St Vincent IPA policies and procedures and has received and reviewed the provider manual's topic areas:

St. Vincent IPA Policies Topic Areas Covered	

- Contracted Health Plans
- Provider Responsibilities
- SVIPA Provider Rosters
  o Primary Care & Specialists
  o Urgent Cares and Laboratories
	- Capitation Reports (PCP)
	- Referral Submissions via Aerial Care
	- Submitting encounters & Claims
	- Compliance
	- LA Care & Health Net Attestations

LA Care DSNP Topic Areas Covered	
- Model of Care - Dementia Training - Member Rights - Interdisciplinary Care - Continuity of Care - Behavioral Health	- Critical Incidents - Cultural Competency - Disability Awareness - CMC Care Coordination - Appeals and Grievances - Managed Long Term Services & Supports
Other Topics Areas Covered	
- Member Rights and Responsibilities - Cultural Sensitivity & Customer Service - Access to Care & After-hours Standards - Medi-Cal Managed Care - Federal State Statutes - Medical Management Delegation and Payment Responsibility - Authorizations and Claims - Health Homes, End of Life Services, Palliative Care - Language Assistance Program (LAP)	- Eligibility Verification - Seniors and Persons with Disabilities - Child Health & Disability Prevention(CHDP) - Mental Health - Balance Billing - Health Assessments & Provider Toolkits - Case Managements - Sterilization Consent - CMS Marketing Guidelines - Tools to Care for Diverse Populations

For additional resources and training tools, please visit our website:

Compliance - : Physicians DataTrust (www.pdtrust.com)

LA Care website: lacare.org/providers/provider-resources/tools-toolkits Blue

Anthem Medi-Cal website: Anthem.com/providers/polices,guidelines&manuals/provider manual

_____	_____	_____
Provider office Representative	**Signature**	**Date:**
_____	_____	_____
SVIPA Representative	Signature	Date:

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The Patient's Choice for Health Care

L.A. Care HEALTH PLAN

For All of L.A.

Attestation for L.A. Care Health Plan Trainings

As a contracted entity with L.A. Care Health Plan, you and your staff must participate in the New Provider Training as part of the onboarding process, and when Ad hoc trainings or updates are required. You must have all required staff in attendance of training(s), legibly complete the sign-in sheet (All Fields), and the facilitator or Office Manager must attest below that the staff listed on the corresponding sign-in sheet were in attendance for the entire presentation. **Signing this attestation confirms that you and your staff have completed the required training and have received and reviewed "The New Provider Orientation Handbook, provided by L.A. Care Health Plan."** As part of L.A. Care Health Plan's oversight and monitoring activities, L.A. Care Health Plan will review sign-in sheets, attestations, and any other corresponding materials to ensure they are complete, accurate, true, and meet any required deadlines.

Please indicate which training has been completed by you and your staff.

L.A. Care Health (Training Title entered by Facilitator) _____Date Completed:_____

L.A Care Health New Provider Onboarding Training (NPOT)_____Date Completed:_____

L.A. Care Health Model of Care Training (MOC)_____Date Completed:_____

L.A. Care Health General Annual Compliance Training (GACT) _____Date Completed:_____
(MOC, Fraud, Waste and Abuse, General Compliance Training, False Claims Act) Distribution of Policies/Procedures and or Standard of Conducts).

L.A. Care Health Early Periodic Screening Diagnosis and Treatment Training (EPSDT)_____Date Completed:_____

Other (please print title)_____Date Completed:_____

By signing below, I attest that staff listed on the corresponding sign-in sheet representing my organization,_____

a contracted entity with L.A. Care Health Plan, have completed and/or received and reviewed the training listed above.
I attest that my organization will furnish copies of sign-in sheets, attestations, and any other related material at the request of L.A. Care Health Plan.

Name of office manager/individual provider: _____

Title: _____

Signature:_____ Date:_____

Email:_____ Phone: _____

*LA CARE FORMS AND THE LANGUAGE CONTAINED HEREIN ARE NOT TO BE ALTERED

L.A. Care HEALTH PLAN

For All of L.A.

L.A. Care Health Plan Sign-In Sheet

Name of PPG/PCP/Specialist/Hospital/Other: _____

Training Name: _____

Facilitator Name: _____

Facilitator Contact Number: _____

Training Location: _____

Date of Training_____Time of Training:_____

Print Name (First and Last)	Signature	Job Title	Email Address

By signing your name above, you attest that you have completed the training or attended the event indicated on this sign-in sheet.

Health Net
COMMUNITY SOLUTIONS

CONFIRMATION OF NEW PROVIDER TRAINING

Please complete the following and submit it within 48 hours via email to HN_Provider_Relations@healthnet.com, or send it via fax to 1-855-863-5987.

REQUIRED: Initial #1 OR #2

1. _____ (initial) I have received the new provider training materials from Health Net Community Solutions, Inc. (Health Net), reviewed them for training purposes, and understand essential components of Health Net's Medi-Cal plan, including basic information about public health programs available to Health Net Medi-Cal members, Health Net's quality improvement program, and interpreter services and provider tools to care for diverse populations.

OR

2. _____ (initial) I have completed Health Net's new provider training online on the provider website and understand essential components of Health Net's Medi-Cal plan, including basic information about public health programs available to Health Net Medi-Cal members, Health Net's quality improvement program, and interpreter services and provider tools to care for diverse populations.

REQUIRED: Initial #3

3. _____ (initial) In addition, I understand my responsibilities related to Health Net's Medi-Cal managed care program services, policies and procedures, and ways to communicate between providers, members and Health Net. I understand how to access and find information on Health Net's provider website about Medi-Cal benefits and services, claims and payment policies, California Children's Services (CCS)-eligible conditions and referral processes, case management services, tools to care for a diverse population, and operations manuals located under *Working with Health Net > Contractual > Provider Library*.

Provider name (PRINT)	Provider signature	Date

Provider address (street, city, ZIP)

Phone number	Email address	Tax identification number (TIN)

INTERNAL USE ONLY

Received date	Data entry date	Provider representative

Health Net®

Provider Training Sign-In Sheet

Trainer Name: _____

DATE: _____

TYPE OF TRAINING:

	New Provider Onboarding		PM160 Online Submission		Tool Kit:
	S.B.I.R.T.		Newborn Referral Process		Other:

PLEASE FILL OUT PROVIDER /CLINIC INFORMATION BELOW - OR- STAMP CLINIC INFO HERE

PROVIDER/CLINIC NAME: _____

PROVIDER NPI: _____

PROVIDER ADDRESS: _____

CITY: _____ ZIP: _____

PROVIDER TEL: _____ FAX: _____

ATTENDEES

	FULL NAME	POSITION	EMAIL ADDRESS (ONLY IF USED FOR WORK PURPOSES)	PHONE NUMBER	SIGNATURE
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

blue california
Promise Health Plan

Medi-Cal
Newly Contracted Provider Training Attestation

To operate in full compliance with the Contract and all applicable Federal and State statutes and regulations, BSCPHP delegated entities must ensure that Network Providers receive provider training **within ten (10) working days** after placing a newly contracted provider on active status.

Note: Before BSCPHP assigns members under this Contract, the Delegated Business Partner is responsible for providing Network Provider education specific to the delegated entity's processes (unless it is a health plan requirement) and the Medi-Cal Managed Care Services program. **Please check the boxes below to confirm that you have received training as it relates to Medi-Cal Managed Care services (including, but not limited to) and has access to the following:**

☑ Medi-Cal Managed Services Program
- Member Rights
  - Member must be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain the confidentiality of the Member's medical information.
  - Member will be provided with information about the plan and its services, including Covered Services,
  - Member will be able to choose a Primary Care Provider within the Contractor's Network.
  - Member will be allowed to participate in decision-making regarding their health care, including the right to refuse treatment.
  - To voice Grievances, either verbally or in writing, about the organization or the care received.
  - To formulate advance directives.
  - Member will be allowed to have access to family planning services, Federally Qualified Health Centers, American Indian Health Service Programs, sexually transmitted disease services, and Emergency Services outside the Contractor's Network pursuant to the federal law.
- Member Services
  - Maintain the level of knowledgeable and trained staff sufficient to provide Member services to Members or Potential Enrollees and all other services covered under this Contract.
  - All contractually required Member or Potential Enrollee service functions, including policies, procedures, and scope of benefits of this contract.
  - Provides necessary support to Members with chronic conditions (such as asthma, diabetes, congestive heart failure) and disabilities, including assisting Members with Grievance and Appeal resolution, access barriers and disability issues, and referral to appropriate clinical services staff.
  - Refer Potential Enrollees to the DHCS enrollment broker, Health Care Options (HCO), when Potential Enrollees make a request for enrollment with the Contractor.
- Evidence-Based Practice Guidelines (specific to the PPG/MSO/IPA)
- Clinical Protocols (specific to the PPG/MSO/IPA)
- Cultural Awareness & Sensitivity, developed by DHCS, for Seniors and Persons with Disabilities and chronic conditions.
- Sharing information methods between the PPG/MSO/IPA, Network provider, Member, and/or other healthcare professionals.
- How the PPG/MSO/IPA will share clinical protocols and evidence-based practices guidelines (e.g., provider portal, website.) for Out-of-Network/Non-Contracted Providers, who will not receive Network Provider Training.

☑ Access to Policies and Procedures (P&Ps) that cover (but are not limited to) the following:
- Services (e.g., Provider Education, Panel Status Changes, etc.)
- Policies (e.g., Prior Authorization, Pre-Natal Services, Member Satisfaction, etc.)

Q# YYYY **Medi-Cal**
Newly Contracted Provider Training Attestation

- Procedures (e.g., DHCS Recommended Care Standards, Continuity of Care, Special Needs Plan (SNP), etc.)
- Any modifications to existing services, policies, and/or procedures.

☑ Compliance/Standards of Conduct,

☑ Training. Fraud, Waste and Abuse Training, and

☑ Access to Provider Manual(s). The Provider Manual is a comprehensive online reference tool for the Provider and their staff. It should be used as a point of reference regarding (but not limited to) administrative, prior authorization, and referral processes, claims and encounter submission processes, continuity of care requirements, and plan benefits; In addition, the Provider Manual shall also address clinical practice guidelines, availability and access standards, care management programs, and Enrollee rights.

I, _____, have completed the Newly Contracted Provider Training on MM/DD/YYYY with St Vincent IPA on the subjects listed above and have access to the provider manual as stipulated by the California Department of Health Care Services (DHCS) contractual requirements.

_____ MM/DD/YYYY

Newly Contracted Provider Signature **Date**

_____ MM/DD/YYYY

NPI# **Contract Effective Date**

I, (Provider's Office Manager Name), attest that the applicable subjects from the Newly Contracted Provider Training have been conducted with the office staff.

_____ MM/DD/YYYY

Office Manager Signature **Date**

Note: *If you do not have an office manager, please provide the name and title of who conducted the training for the office staff.*

I, (PPG/MSO/IPA Rep Name), attest that the newly contracted provider and office staff have completed the required Medi-Cal Managed Care Services training stipulated by the California Department of Health Care Services (DHCS) contractual requirements. I further attest that ongoing provider training and/or updates to Compliance, Fraud, Waste and Abuse training, Clinical Protocols and guidelines, the organization's policies, and procedures, etc., will be conducted/provided to the newly contracted provider named above.

PPG/MSO/IPA Rep Signature: _____ **Date:** MM/DD/YYYY

PPG/MSO/IPA Rep Title: _____

PPG/MSO/IPA Name: _____

Note: *Please return this attestation, including the evidence of training and completed documentation pertaining to Newly Contracted Provider Training to:* BSCProviderTraining@blueshieldca.com.

St. Vincent IPA

The Patients' Choice for Health Care

2024 DOWNSTREAM ATTESTATION

This attestation documents your organization's adherence to compliance and privacy requirements, as well as plan-specific training requirements. These requirements are further described in the training materials and other resources accessible at pdtrust.com/compliance.

1. **Standards of Conduct and/or Compliance Policies**
   All workforce members and downstream entities are provided the PDT Code of Conduct (or equivalent) within 30 days of hire or contracting, annually thereafter, and upon revision.
   Annual SoC distribution was completed on, or will be completed by: ___/___/2024

2. **General Compliance Training & Fraud, Waste and Abuse ("FWA") Training**
   All workforce members and downstream entities complete General Compliance and FWA training within 30 days of hire or contracting and annually thereafter.
   Annual GC/FWA training was completed on, or will be completed by: ___/___/2024

3. **Privacy & Security (HIPAA) Training**
   All workforce members and business associates complete privacy and security training upon onboarding, annually thereafter, and upon revision.
   Annual HIPAA training was completed on, or will be completed by: ___/___/2024

4. **OIG/GSA Exclusion Screenings**
   All employees and downstream entities are screened against the OIG and GSA exclusion lists prior to hire or contracting and monthly thereafter. Resolution of potential matches is documented.

5. **Offshore Operations**
   Our organization does not engage in offshore operations (including work performed offshore by a US-based business) involving IPA member PHI. Otherwise, our organization will report such operations to the IPA immediately for review, and annually thereafter.

6. **Subcontractor Oversight**
   Our organization conducts sufficient oversight to ensure that downstream entities and business associates meet all compliance and privacy program requirements.

7. **Cultural Competency & Language Assistance Program (LAP)**
   Providers and staff complete cultural competency, sensitivity, and diversity training consistent with national Culturally and Linguistically Appropriate Services (CLAS) standards.

8. **Health Plan Required Training**
   Providers and staff complete Model of Care (MOC) training and any additional plan-specific training required by affiliated health plans.

9. **Critical Incident Reporting**
   Providers, staff, and downstream entities are informed of the obligation and methods to report suspected Critical Incidents. In turn, our organization reports applicable incidents to the IPA.

OVER →

10. Document Retention and Evidence Requests

Our organization and our subcontractors save all documentation pertaining to IPA business for a minimum of ten years, including evidence of the above requirements. Our organization agrees to produce this documentation upon request, or face corrective actions.

Signature of Organization's Authorized Representative	Date
Organization's Authorized Representative Name	Title
Organization Name	Tax ID
Organization Email Address	Phone Number

Return this completed attestation via email, fax, or SignNow. Please contact us if you have any questions.

PHONE: 888-255-5053 **EMAIL**: prsvipa@pdtrust.com **FAX**: 562-207-6558

HEALTH PLAN REQUIREMENTS

PROVIDER*Update*

Health Net®

REGULATORY | DECEMBER 18, 2018 | UPDATE 18-908 | 2 PAGES

Training and Attestation Requirements

Newly contracting providers must complete required Medi-Cal training, and sign and return the training attestation form

Participating physician groups (PPGs) delegated to perform credentialing on behalf of Health Net* are required to ensure that newly contracting Medi-Cal providers complete required provider training, sign the training attestation form and return it as part of the contracting package.

Effective February 1, 2019, the PPG must send a copy of the signed attestation form to Health Net with notification that the PPG has a newly contracting Medi-Cal provider. Before the provider can be activated in the Health Net system of record, Health Net must receive a signed attestation form along with the required pages of the signed contract.

TRAINING ATTESTION FORM ADDED TO CREDENTIALING CHECKLIST

The updated attestation form, which is included in the packet, is a required component of the provider credentialing process and has been added as a line item to the credentialing checklist. The form must be signed by the provider who completed the trainings. Staff members cannot sign the attestation on behalf of a provider, and providers cannot waive required trainings. A copy of the updated form is attached for reference.

TRAINING MATERIALS AND ATTESTATION FORM AVAILABLE ONLINE

Providers can access educational training materials and the updated attestation form online on Health Net's provider website at provider.healthnet.com under *Provider Support > New Provider Onboarding Packets > Health Net Medi-Cal New Provider Resources*.

IN-PERSON TRAINING

In-person training is available. Providers who would prefer in-person training may contact Provider Relations by email at hn_provider_relations@healthnet.com to request a training session.

ADDITIONAL INFORMATION

Providers are encouraged to access the provider portal online at provider.healthnet.com for real-time information, including eligibility verification, claims status, prior authorization status, plan summaries, and more.

If you have questions regarding the information contained in this update, contact the Health Net Medi-Cal Provider Services Center within 60 days at 1-800-675-6110.

THIS UPDATE APPLIES TO **CALIFORNIA** PROVIDERS:

- ○ Physicians
- ● Participating Physician Groups
- ○ Hospitals
- ○ Ancillary Providers

LINES OF BUSINESS:

- ○ HMO/POS/HSP
- ○ PPO
- ○ EPO
- ○ Medicare Advantage (HMO)
- ● Medi-Cal
  - ● Kern
  - ● Los Angeles
    - ○ Molina
  - ○ Riverside
  - ● Sacramento
  - ○ San Bernardino
  - ● San Diego
  - ● San Joaquin
  - ● Stanislaus
  - ● Tulare

PROVIDER SERVICES

1-800-675-6110
provider.healthnet.com

PROVIDER COMMUNICATIONS

provider.communications@healthnet.com
fax 1-800-937-6086

Provider Satisfaction Survey

In our effort to improve our services to our physicians, your feedback is needed. St. Vincent IPA requests you complete a provider satisfaction survey annually. We hope you will take a couple minutes to complete the attached survey and return by **fax (562) 924-1603** or **email Prsvipa@pdtrust.com** by the end of the year.

Should you require additional copies of the survey or have any questions, please feel free to contact Provider Relations at **(562) 860-8771 ext. 112**, or by **email Prsvipa@pdtrust.com**.

We thank you for your hard work and support for St. Vincent IPA.

ST. VINCENT IPA

The Patient's Choice for Health Care

PROVIDER SATISFACTION SURVEY

Date

Dear St. Vincent IPA Physician:

St. Vincent IPA is striving to improve the service we provide our physicians. Your input is very important to us. Please complete the following survey with your comments and return it by **Day, Month, Day, Year.** Please check the appropriate response below:

Provider Name: _____ **PCP** ☐ **SPC** ☐

5=Strongly Agree 4=Agree 3=Neutral 2=Disagree 1=Strongly Disagree

	5	4	3	2	1
1. St. Vincent IPA responds to your calls promptly.					
2. St. Vincent IPA staff answers your questions to your satisfaction.					
3. St. Vincent IPA staff is courteous and helpful when you call.					
4. Your St. Vincent IPA claims are processed in a timely fashion (within 60 days).					
5. Questions regarding claims are handled quickly.					
6. St. Vincent IPA referral forms are user friendly.					
7. Referrals are returned to you timely.					
8. Questions regarding referrals are handled appropriately.					
9. Contracted ancillary providers render acceptable services:					
a. Lab – Unilab/Quest Diagnostic					
b. Physical Therapy – St. Vincent Medical Center					
c.1. Radiology – St. Vincent Radiological Medical Group					
c.2. Radiology – Samaritan Imaging					
d.1. Mammography – St. Vincent Radiological Medical Group					
d.2. Mammography – Samaritan Imaging					

Comments: _____

_____

_____

_____

Please return survey via fax to 562-924-1603

Thank you for your response.

Member Satisfaction Survey

In our effort to continuously improve our delivery of services to our members, we need your help capturing feedback from our patient community. For every St. Vincent IPA member that comes in, please have member complete survey and return by fax: **(562) 924-1603** or email: **Prsvipa@pdtrust.com** by the end of the year.

Please be advised, submission of the member satisfaction survey impacts your Surplus Distribution to be distributed in Month Year. You must submit at least four (4) completed member satisfaction surveys to qualify for this portion (7.5%) of the final Surplus Distribution.

If you have less than 4 members, you will need to submit member satisfaction survey for each of your members in order to qualify for this portion of the PCP Surplus Distribution.

Should you require additional copies of the survey or have any questions, please feel free to contact Provider Relations at **(562) 860-8771 ext. 112** or you can email **Prsvipa@pdtrust.com**.

We greatly appreciate your help with this effort to assist St. Vincent IPA better serve our communities and we thank you for your hard work and support for St. Vincent IPA.

CUSTOMER SATISFACTION SURVEY

Doctor Seeing today:		**PCP on ID Card:**
Age:	**Gender:** ☐M ☐F	**Today's Date:**

We constantly strive to serve our member/customer population better. We are evaluating your satisfaction with the Primary Care Physician (PCP) you have chosen to manage your medical care, and your ability to receive the services you feel are appropriate for you. Please take a minute, while you are waiting in your doctor/PCP's office and answer a few questions. Thank you in advance for helping us improve our service to you.

1. In the last 12 months, how often did you get an appointment with your PCP as soon as you wanted? ___(always) ___(usually) ___(sometimes) ___(never)

2. In the last 12 months, when you called your PCP office during regular office hours, how often did you get the advice or help you needed?
___(always) ___(usually) ___(sometimes) ___(never)

3. In the last 12 months, how often did your PCP **listen** carefully to you?
___(always) ___(usually) ___(sometimes) ___(never)

4. In the last 12 months, how often did your PCP **explain** things in a way you could understand? ___(always) ___(usually) ___(sometimes) ___(never)

5. In the last 12 months, how often was the office staff at your PCP's office as helpful as you thought they should be? ___(always) ___(usually) ___(sometimes) ___(never)

6. In the last 12 months, when you needed care right away (during office hours) for an illness, injury or condition, how often did you get care as soon as you wanted?
___(always) ___(usually) ___(sometimes) ___(never)

7. In the last 12 months, when your PCP sent you for a blood test, x-ray, or other test, did someone from your PCP office follow-up to give you the test results?
___(Yes, always) ___(Yes, sometimes) ___(No, never)

8. In the last 12 months, if you were referred outside your PCP office, how often were you notified timely of the approval for the service?
___(always) ___(usually) ___(sometimes) ___(never)

9. When waiting in your PCP office, how long do you usually wait, from the time of your scheduled appointment to the time your doctor sees you?
___(5-10 min) ___(11-20min) ___(21-30min) ___(>30min) ___(>45min) ___(>60min)

10. Using any number from 0 to 10 (where10 is the best and 0 is the worst) what number would you use to rate your PCP?
___(10) ___(9) ___(8) ___(7) ___(6) ___(5) ___(4) ___(3) ___(2) ___(1) ___(0)

***Please write any helpful comments you may have on the back of this form.**

END